

Exhibit 8

Quality Payment PROGRAM

2023 MIPS Data Validation – Improvement Activities Performance Category Changes

ID	Activity Name	V1_2022 (09/20/2022)
IA_PSPA_7	Use of QCDR data for ongoing practice assessment and improvements	<ul style="list-style-type: none"> Consolidated IA_BE_7, IA_BE_8, and IA_PM_7 into one activity (IA_PSPA_7)
IA_PSPA_19	Implementation of formal quality improvement methods, practice changes, or other practice improvement processes	<ul style="list-style-type: none"> Consolidated IA_PSPA_19 and IA_PSPA_20 into one activity (IA_PSPA_19)
IA_PSPA_10	Obtain or Renew an Approved Waiver for Provision of Buprenorphine as Medication-Assisted Treatment for Opioid Use Disorder	<ul style="list-style-type: none"> Added a note limiting the attestation Re-categorized to BMH as IA_BMH_13
IA_CC_14	Practice Improvements that Engage Community Resources to Address Drivers of Health	<ul style="list-style-type: none"> Changed title Changed subcategory to AHE and ID to IA_AHE_12 Updated activity description
IA_CC_13	Practice Improvements to Align with OpenNotes Principles	<ul style="list-style-type: none"> Changed title Require OpenNotes
IA_EPA_6	Create and Implement a Language Access Plan	New Improvement Activity
IA_AHE_10	Adopt Certified Health Information Technology for Security Tags for Electronic Health Record Data	New Improvement Activity
IA_AHE_11	Create and Implement a Plan to Improve Care for Lesbian, Gay, Bisexual, Transgender, and Queer Patients	New Improvement Activity
IA_ERP_6	COVID-19 Vaccine Achievement for Practice Staff	New Improvement Activity

Version History

Date	Change Description
12/30/2022	Original version.



Quality Payment PROGRAM

2023 MIPS Data Validation – Improvement Activities Deleted for 2023

ID	Activity Name
IA_BE_7	Participation in a QCDR, that promotes use of patient engagement tools.
IA_BE_8	Participation in a QCDR, that promotes collaborative learning network opportunities that are interactive.
IA_PM_7	Use of QCDR for feedback reports that incorporate population health
IA_PSPA_6	Consultation of the Prescription Drug Monitoring program
IA_PSPA_20	Leadership engagement in regular guidance and demonstrated commitment for implementing practice improvement changes
IA_PSPA_30	PCI Bleeding Campaign

Version History

Date	Change Description
12/30/2022	Original version.



Quality Payment PROGRAM

2023 Improvement Activities List

Activity Name	Activity Description	Activity ID	Subcategory Name	Activity Weighting
Provide 24/7 Access to MIPS Eligible Clinicians or Groups Who Have Real-Time Access to Patient's Medical Record	Provide 24/7 access to MIPS eligible clinicians, groups, or care teams for advice about urgent care (e.g., MIPS eligible clinician and care team access to medical record, cross-coverage with access to medical record, or protocol-driven nurse line with access to medical record) that could include one or more of the following: <ul style="list-style-type: none"> • Expanded hours in evenings and weekends with access to the patient medical record (e.g., coordinate with small practices to provide alternate hour office visits and urgent care); • Use of alternatives to increase access to care team by MIPS eligible clinicians and groups, such as e-visits, phone visits, group visits, home visits and alternate locations (e.g., senior centers and assisted living centers); and/or • Provision of same-day or next-day access to a MIPS eligible clinician, group or care team when needed for urgent care or transition management. 	IA_EPA_1	Expanded Practice Access	High
Use of telehealth services that expand practice access	Create and implement a standardized process for providing telehealth services to expand access to care.	IA_EPA_2	Expanded Practice Access	Medium
Collection and use of patient experience and satisfaction data on access	Collection of patient experience and satisfaction data on access to care and development of an improvement plan, such as outlining steps for improving communications with patients to help understanding of urgent access needs.	IA_EPA_3	Expanded Practice Access	Medium
Additional improvements in access as a result of QIN/QIO TA	As a result of Quality Innovation Network-Quality Improvement Organization technical assistance, performance of additional activities that improve access to services or improve care coordination (for example, investment of on-site diabetes educator).	IA_EPA_4	Expanded Practice Access	Medium



Participation in User Testing of the Quality Payment Program Website (https://qpp.cms.gov/)	User participation in the Quality Payment Program website testing is an activity for eligible clinicians who have worked with CMS to provide substantive, timely, and responsive input to improve the CMS Quality Payment Program website through product user-testing that enhances system and program accessibility, readability and responsiveness as well as providing feedback for developing tools and guidance thereby allowing for a more user-friendly and accessible clinician and practice Quality Payment Program website experience.	IA_EPA_5	Expanded Practice Access	Medium
Create and Implement a Language Access Plan	Create and implement a language access plan to address communication barriers for individuals with limited English proficiency. The language access plan must align with standards for communication and language assistance defined in the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care (https://thinkculturalhealth.hhs.gov/clas).	IA_EPA_6	Expanded Practice Access	High
Anticoagulant Management Improvements	Individual MIPS eligible clinicians and groups who prescribe anti-coagulation medications (including, but not limited to oral Vitamin K antagonist therapy, including warfarin or other coagulation cascade inhibitors) must attest that for 75 percent of their ambulatory care patients receiving these medications are being managed with support from one or more of the following improvement activities: <ul style="list-style-type: none"> • Participation in a systematic anticoagulation program (coagulation clinic, patient self-reporting program, or patient self-management program); • Patients are being managed by an anticoagulant management service, that involves systematic and coordinated care, incorporating comprehensive patient education, systematic prothrombin time (PT-INR) testing, tracking, follow-up, and patient communication of results and dosing decisions; • Patients are being managed according to validated electronic decision support and clinical management tools that involve systematic and coordinated care, incorporating comprehensive patient education, systematic PT-INR testing, tracking, follow-up, and patient communication of results and dosing decisions; • For rural or remote patients, patients are managed using remote monitoring or telehealth options that involve systematic and coordinated care, incorporating comprehensive patient education, systematic PT-INR testing, tracking, follow-up, and patient communication of results and dosing decisions; or • For patients who demonstrate motivation, competency, and adherence, patients are managed using either a patient self-testing (PST) or patient-self-management (PSM) program. 	IA_PM_2	Population Management	High
RHC, IHS or FQHC quality improvement activities	Participating in a Rural Health Clinic (RHC), Indian Health Service Medium Management (IHS), or Federally Qualified Health Center in ongoing engagement activities that contribute to more formal quality reporting, and that include receiving quality data back for broader quality improvement and benchmarking improvement which will ultimately benefit patients. Participation in Indian Health Service, as an improvement activity, requires MIPS eligible clinicians and groups to deliver care to federally recognized American Indian and Alaska Native populations in the U.S. and in the course of that care implement continuous clinical practice improvement including reporting data on quality of services being provided and receiving feedback to make improvements over time.	IA_PM_3	Population Management	High

Glycemic management services	<p>For outpatient Medicare beneficiaries with diabetes and who are prescribed antidiabetic agents (e.g., insulin, sulfonylureas), MIPS eligible clinicians and groups must attest to having:</p> <p>For the first performance year, at least 60 percent of medical records with documentation of an individualized glycemic treatment goal that:</p> <p>a) Takes into account patient-specific factors, including, at least 1) age, 2) comorbidities, and 3) risk for hypoglycemia, and</p> <p>b) Is reassessed at least annually.</p> <p>The performance threshold will increase to 75 percent for the second performance year and onward.</p> <p>Clinician would attest that, 60 percent for first year, or 75 percent for the second year, of their medical records that document individualized glycemic treatment represent patients who are being treated for at least 90 days during the performance period.</p>	IA_PM_4	Population Management	High
Engagement of community for health status improvement	Take steps to improve health status of communities, such as collaborating with key partners and stakeholders to implement evidenced-based practices to improve a specific chronic condition. Refer to the local Quality Improvement Organization (QIO) for additional steps to take for improving health status of communities as there are many steps to select from for satisfying this activity. QIOs work under the direction of CMS to assist MIPS eligible clinicians and groups with quality improvement, and review quality concerns for the protection of beneficiaries and the Medicare Trust Fund.	IA_PM_5	Population Management	Medium
Use of Toolsets or Other Resources to Close Health and Health Care Inequities Across Communities	Address inequities in health outcomes by using population health data analysis tools to identify health inequities in the community and practice and assess options for effective and relevant interventions such as Population Health Toolkit or other resources identified by the clinician, practice, or by CMS. Based on this information, create, refine, and implement an action plan to address and close inequities in health outcomes and/or health care access, quality, and safety.	IA_PM_6	Population Management	Medium
Regular review practices in place on targeted patient population needs	Implement regular reviews of targeted patient population needs, such as structured clinical case reviews, which include access to reports that show unique characteristics of MIPS eligible clinician's patient population, identification of underserved patients, and how clinical treatment needs are being tailored, if necessary, to address unique needs and what resources in the community have been identified as additional resources. The review should consider how structural inequities, such as racism, are influencing patterns of care and consider changes to acknowledge and address them. Reviews should stratify patient data by demographic characteristics and health related social needs to appropriately identify differences among unique populations and assess the drivers of gaps and disparities and identify interventions appropriate for the needs of the sub-populations.	IA_PM_11	Population Management	Medium

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Implementation of methodologies for improvements in longitudinal care management for high risk patients	Provide longitudinal care management to patients at high risk for adverse health outcome or harm that could include one or more of the following: <ul style="list-style-type: none"> • Use a consistent method to assign and adjust global risk status for all empaneled patients to allow risk stratification into actionable risk cohorts. Monitor the risk-stratification method and refine as necessary to improve accuracy of risk status identification; • Use a personalized plan of care for patients at high risk for adverse health outcome or harm, integrating patient goals, values and priorities; and/or • Use on-site practice-based or shared care managers to proactively monitor and coordinate care for the highest risk cohort of patients. 	IA_PM_14	Population Management	Medium
Implementation of episodic care management practice improvements	Provide episodic care management, including management across transitions and referrals that could include one or more of the following: <ul style="list-style-type: none"> • Routine and timely follow-up to hospitalizations, ED visits and stays in other institutional settings, including symptom and disease management, and medication reconciliation and management; and/or • Managing care intensively through new diagnoses, injuries and exacerbations of illness. 	IA_PM_15	Population Management	Medium
Implementation of medication management practice improvements	Manage medications to maximize efficiency, effectiveness and safety that could include one or more of the following: <ul style="list-style-type: none"> • Reconcile and coordinate medications and provide medication management across transitions of care settings and eligible clinicians or groups; • Integrate a pharmacist into the care team; and/or • Conduct periodic, structured medication reviews. 	IA_PM_16	Population Management	Medium
Participation in Population Health Research	Participation in federally and/or privately funded research that identifies interventions, tools, or processes that can improve a targeted patient population.	IA_PM_17	Population Management	Medium
Provide Clinical-Community Linkages	Engaging community health workers to provide a comprehensive link to community resources through family-based services focusing on success in health, education, and self-sufficiency. This activity supports individual MIPS eligible clinicians or groups that coordinate with primary care and other clinicians, engage and support patients, use of health information technology, and employ quality measurement and improvement processes. An example of this community based program is the NCQA Patient-Centered Connected Care (PCCC) Recognition Program or other such programs that meet these criteria.	IA_PM_18	Population Management	Medium
Glycemic Screening Services	For at-risk outpatient Medicare beneficiaries, individual MIPS eligible clinicians and groups must attest to implementation of systematic preventive approaches in clinical practice for at least 60 percent for the 2018 performance period and 75 percent in future years, of electronic medical records with documentation of screening patients for abnormal blood glucose according to current US Preventive Services Task Force (USPSTF) and/or American Diabetes Association (ADA) guidelines.	IA_PM_19	Population Management	Medium

Glycemic Referring Services	For at-risk outpatient Medicare beneficiaries, individual MIPS eligible clinicians and groups must attest to implementation of systematic preventive approaches in clinical practice for at least 60 percent for the CY 2018 performance period and 75 percent in future years, of medical records with documentation of referring eligible patients with prediabetes to a CDC-recognized diabetes prevention program operating under the framework of the National Diabetes Prevention Program.	IA_PM_20	Population Management	Medium
Advance Care Planning	Implementation of practices/processes to develop advance care planning that includes: documenting the advance care plan or living will within the medical record, educating clinicians about advance care planning motivating them to address advance care planning needs of their patients, and how these needs can translate into quality improvement, educating clinicians on approaches and barriers to talking to patients about end-of-life and palliative care needs and ways to manage its documentation, as well as informing clinicians of the healthcare policy side of advance care planning.	IA_PM_21	Population Management	Medium
Implementation of Use of Specialist Reports Back to Referring Clinician or Group to Close Referral Loop	Performance of regular practices that include providing specialist reports back to the referring individual MIPS eligible clinician or group to close the referral loop or where the referring individual MIPS eligible clinician or group initiates regular inquiries to specialist for specialist reports which could be documented or noted in the EHR technology.	IA_CC_1	Care Coordination	Medium
Implementation of improvements that contribute to more timely communication of test results	Timely communication of test results defined as timely identification of abnormal test results with timely follow-up.	IA_CC_2	Care Coordination	Medium
Regular training in care coordination	Implementation of regular care coordination training.	IA_CC_7	Care Coordination	Medium
Implementation of documentation improvements for practice/process improvements	Implementation of practices/processes that document care coordination activities (e.g., a documented care coordination encounter that tracks all clinical staff involved and communications from date patient is scheduled for outpatient procedure through day of procedure).	IA_CC_8	Care Coordination	Medium
Implementation of practices/processes for developing regular individual care plans	Implementation of practices/processes, including a discussion on care, to develop regularly updated individual care plans for at-risk patients that are shared with the beneficiary or caregiver(s). Individual care plans should include consideration of a patient's goals and priorities, as well as desired outcomes of care.	IA_CC_9	Care Coordination	Medium

Care transition documentation practice improvements	In order to receive credit for this activity, a MIPS eligible clinician must document practices/processes for care transition with documentation of how a MIPS eligible clinician or group carried out an action plan for the patient with the patient's preferences in mind (that is, a "patient-centered" plan) during the first 30 days following a discharge. Examples of these practices/processes for care transition include: staff involved in the care transition; phone calls conducted in support of transition; accompaniments of patients to appointments or other navigation actions; home visits; patient information access to their medical records; real time communication between PCP and consulting clinicians; PCP included on specialist follow-up or transition communications.	IA_CC_10	Care Coordination	Medium
Care transition standard operational improvements	Establish standard operations to manage transitions of care that could include one or more of the following: <ul style="list-style-type: none"> • Establish formalized lines of communication with local settings in which empaneled patients receive care to ensure documented flow of information and seamless transitions in care; and/or • Partner with community or hospital-based transitional care services. 	IA_CC_11	Care Coordination	Medium
Care coordination agreements that promote improvements in patient tracking across settings	Establish effective care coordination and active referral management that could include one or more of the following: <ul style="list-style-type: none"> • Establish care coordination agreements with frequently used consultants that set expectations for documented flow of information and MIPS eligible clinician or MIPS eligible clinician group expectations between settings. Provide patients with information that sets their expectations consistently with the care coordination agreements; • Track patients referred to specialist through the entire process; and/or • Systematically integrate information from referrals into the plan of care. 	IA_CC_12	Care Coordination	Medium
Practice improvements to align with OpenNotes Principles	Adherence to the principles described in the OpenNotes initiative (https://www.opennotes.org) to ensure that patients have full access to their patient information to guide patient care.	IA_CC_13	Care Coordination	Medium
PSH Care Coordination	Participation in a Perioperative Surgical Home (PSH) that provides a patient-centered, physician-led, interdisciplinary, and team-based system of coordinated patient care, which coordinates care from pre-procedure assessment through the acute care episode, recovery, and post-acute care. This activity allows for reporting of strategies and processes related to care coordination of patients receiving surgical or procedural care within a PSH. The clinician must perform one or more of the following care coordination activities: <ul style="list-style-type: none"> • Coordinate with care managers/navigators in preoperative clinic to plan and implementation comprehensive post discharge plan of care; • Deploy perioperative clinic and care processes to reduce post-operative visits to emergency rooms; • Implement evidence-informed practices and standardize care across the entire spectrum of surgical patients; or • Implement processes to ensure effective communications and education of patients' post-discharge instructions. 	IA_CC_15	Care Coordination	High

Primary Care Physician and Behavioral Health Bilateral Electronic Exchange of Information for Shared Patients	The primary care and behavioral health practices use the same electronic health record system for shared patients or have an established bidirectional flow of primary care and behavioral health records.	IA_CC_16	Care Coordination	Medium
Patient Navigator Program	Implement a Patient Navigator Program that offers evidence-based resources and tools to reduce avoidable hospital readmissions, utilizing a patient-centered and team-based approach, leveraging evidence-based best practices to improve care for patients by making hospitalizations less stressful, and the recovery period more supportive by implementing quality improvement strategies.	IA_CC_17	Care Coordination	High
Relationship-Centered Communication	In order to receive credit for this activity, MIPS eligible clinicians must participate in a minimum of eight hours of training on relationship-centered care tenets such as making effective open-ended inquiries; eliciting patient stories and perspectives; listening and responding with empathy; using the ART (ask, respond, tell) communication technique to engage patients, and developing a shared care plan. The training may be conducted in formats such as, but not limited to: interactive simulations practicing the skills above, or didactic instructions on how to implement improvement action plans, monitor progress, and promote stability around improved clinician communication.	IA_CC_18	Care Coordination	Medium
Tracking of clinician's relationship to and responsibility for a patient by reporting MACRA patient relationship codes	To receive credit for this improvement activity, a MIPS eligible clinician must attest that they reported MACRA patient relationship codes (PRC) using the applicable HCPCS modifiers on 50 percent or more of their Medicare claims for a minimum of a continuous 90-day period within the performance period. Reporting the PRC modifiers enables the identification of a clinician's relationship with, and responsibility for, a patient at the time of furnishing an item or service. See the CY 2018 PFS final rule (82 FR 53232 through 53234) for more details on these codes.	IA_CC_19	Care Coordination	High
Use of certified EHR to capture patient reported outcomes	To improve patient access, perform activities beyond routine care that enable capture of patient reported outcomes (for example, related to functional status, symptoms and symptom burden, health behaviors, or patient experience) or patient activation measures (that is, measures of patient involvement in their care) through use of certified electronic health record technology, and record these outcomes data for clinician review.	IA_BE_1	Beneficiary Engagement	Medium
Engagement with QIN-QIO to implement self-management training programs	Engagement with a Quality Innovation Network-Quality Improvement Organization, which may include participation in self-management training programs such as diabetes.	IA_BE_3	Beneficiary Engagement	Medium

Engagement of patients through implementation of improvements in patient portal	To receive credit for this activity, MIPS eligible clinicians must provide access to an enhanced patient/caregiver portal that allows users (patients or caregivers and their clinicians) to engage in bidirectional information exchange. The primary use of this portal should be clinical and not administrative. Examples of the use of such a portal include, but are not limited to: brief patient reevaluation by messaging; communication about test results and follow up; communication about medication adherence, side effects, and refills; blood pressure management for a patient with hypertension; blood sugar management for a patient with diabetes; or any relevant acute or chronic disease management.	IA_BE_4	Beneficiary Engagement	Medium
Enhancements/regular updates to practice websites/tools that also include considerations for patients with cognitive disabilities	Enhancements and ongoing regular updates and use of websites/tools that include consideration for compliance with section 508 of the Rehabilitation Act of 1973 or for improved design for patients with cognitive disabilities. Refer to the CMS website on Section 508 of the Rehabilitation Act https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/Section508/index.html?redirect=/InfoTechGenInfo/07_Section508.asp that requires that institutions receiving federal funds solicit, procure, maintain and use all electronic and information technology (EIT) so that equal or alternate/comparable access is given to members of the public with and without disabilities. For example, this includes designing a patient portal or website that is compliant with section 508 of the Rehabilitation Act of 1973.	IA_BE_5	Beneficiary Engagement	Medium
Regularly Assess Patient Experience of Care and Follow Up on Findings	Collect and follow up on patient experience and satisfaction data. This activity also requires follow-up on findings of assessments, including the development and implementation of improvement plans. To fulfill the requirements of this activity, MIPS eligible clinicians can use surveys (e.g., Consumer Assessment of Healthcare Providers and Systems Survey), advisory councils, or other mechanisms. MIPS eligible clinicians may consider implementing patient surveys in multiple languages, based on the needs of their patient population.	IA_BE_6	Beneficiary Engagement	High
Use evidence-based decision aids to support shared decision-making	Use evidence-based decision aids to support shared decision-making.	IA_BE_12	Beneficiary Engagement	Medium
Engage Patients and Families to Guide Improvement in the System of Care	Engage patients and families to guide improvement in the system of care by leveraging digital tools for ongoing guidance and assessments outside the encounter, including the collection and use of patient data for return-to-work and patient quality of life improvement. Platforms and devices that collect patient-generated health data (PGHD) must do so with an active feedback loop, either providing PGHD in real or near-real time to the care team, or generating clinically endorsed real or near-real time automated feedback to the patient, including patient reported outcomes (PROs). Examples include patient engagement and outcomes tracking platforms, cellular or web-enabled bi-directional systems, and other devices that transmit clinically valid objective and subjective data back to care teams. Because many consumer-grade devices capture PGHD (for example, wellness devices), platforms or devices eligible for this improvement activity must be, at a minimum, endorsed and offered clinically	IA_BE_14	Beneficiary Engagement	High

	by care teams to patients to automatically send ongoing guidance (one way). Platforms and devices that additionally collect PGHD must do so with an active feedback loop, either providing PGHD in real or near-real time to the care team, or generating clinically endorsed real or near-real time automated feedback to the patient (e.g. automated patient-facing instructions based on glucometer readings). Therefore, unlike passive platforms or devices that may collect but do not transmit PGHD in real or near-real time to clinical care teams, active devices and platforms can inform the patient or the clinical care team in a timely manner of important parameters regarding a patient's status, adherence, comprehension, and indicators of clinical concern.			
Engagement of Patients, Family, and Caregivers in Developing a Plan of Care	Engage patients, family, and caregivers in developing a plan of care and prioritizing their goals for action, documented in the electronic health record (EHR) technology.	IA_BE_15	Beneficiary Engagement	Medium
Promote Self-management in Usual Care	To help patients self-manage their care, incorporate culturally and linguistically tailored evidence-based techniques for promoting self-management into usual care, and provide patients with tools and resources for self-management. Examples of evidence-based techniques to use in usual care include: goal setting with structured follow-up, Teach-back methods, action planning, assessment of need for self-management (for example, the Patient Activation Measure), and motivational interviewing. Examples of tools and resources to provide patients directly or through community organizations include: peer-led support for self-management, condition-specific chronic disease or substance use disorder self-management programs, and self-management materials.	IA_BE_16	Beneficiary Engagement	Medium
Use group visits for common chronic conditions (e.g., diabetes)	Use group visits for common chronic conditions (e.g., diabetes).	IA_BE_19	Beneficiary Engagement	Medium
Improved Practices that Engage Patients Pre-Visit	Implementation of workflow changes that engage patients prior to the visit, such as a pre-visit development of a shared visit agenda with the patient, or targeted pre-visit laboratory testing that will be resulted and available to the MIPS eligible clinician to review and discuss during the patient's appointment.	IA_BE_22	Beneficiary Engagement	Medium
Integration of patient coaching practices between visits	Provide coaching between visits with follow-up on care plan and goals.	IA_BE_23	Beneficiary Engagement	Medium
Financial Navigation Program	In order to receive credit for this activity, MIPS eligible clinicians must attest that their practice provides financial counseling to patients or their caregiver about costs of care and an exploration of different payment options. The MIPS eligible clinician may accomplish this by working with other members of their practice (for example, financial counselor or patient navigator) as part of a team-based care approach in which members of the patient care team collaborate to support patient-centered goals. For example, a financial counselor could provide patients with resources with further information or support options, or facilitate a conversation with a patient or caregiver that could address concerns. This activity may occur during diagnosis	IA_BE_24	Beneficiary Engagement	Medium

	stage, before treatment, during treatment, and/or during survivorship planning, as appropriate.			
Drug Cost Transparency	Provide counseling to patients and/or their caregivers regarding: costs of medications using a real time benefit tool (RTBT) which provides to the prescriber real-time patient-specific formulary and benefit information for drugs, including cost-sharing for a beneficiary.	IA_BE_25	Beneficiary Engagement	High
Participation in an AHRQ-listed patient safety organization	Participation in an AHRQ-listed patient safety organization.	IA_PSPA_1	Patient Safety and Practice Assessment	Medium
Participation in MOC Part IV	<p>In order to receive credit for this activity, a MIPS eligible clinician must participate in Maintenance of Certification (MOC) Part IV. Maintenance of Certification (MOC) Part IV requires clinicians to perform monthly activities across practice to regularly assess performance by reviewing outcomes addressing identified areas for improvement and evaluating the results.</p> <p>Some examples of activities that can be completed to receive MOC Part IV credit are: the American Board of Internal Medicine (ABIM) Approved Quality Improvement (AQI) Program, National Cardiovascular Data Registry (NCDR) Clinical Quality Coach, Quality Practice Initiative Certification Program, American Board of Medical Specialties Practice Performance Improvement Module or American Society of Anesthesiologists (ASA) Simulation Education Network, for improving professional practice including participation in a local, regional or national outcomes registry or quality assessment program; specialty- specific activities including Safety Certification in Outpatient Practice Excellence (SCOPE); American Psychiatric Association (APA) Performance in Practice modules.</p>	IA_PSPA_2	Patient Safety and Practice Assessment	Medium
Participate in IHI Training/Forum Event; National Academy of Medicine, AHRQ Team STEPPS® or Other Similar Activity	For MIPS eligible clinicians not participating in Maintenance of Certification (MOC) Part IV, new engagement for MOC Part IV, such as the Institute for Healthcare Improvement (IHI) Training/Forum Event; National Academy of Medicine, Agency for Healthcare Research and Quality (AHRQ) Team STEPPS®, or the American Board of Family Medicine (ABFM) Performance in Practice Modules.	IA_PSPA_3	Patient Safety and Practice Assessment	Medium
Administration of the AHRQ Survey of Patient Safety Culture	Administration of the AHRQ Survey of Patient Safety Culture and submission of data to the comparative database (refer to AHRQ Survey of Patient Safety Culture website http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/index.html). Note: This activity may be selected once every 4 years, to avoid duplicative information given that some of the modules may change on a year by year basis but over 4 years there would be a reasonable expectation for the set of modules to have undergone substantive change, for the improvement activities performance category score.	IA_PSPA_4	Patient Safety and Practice Assessment	Medium

Use of QCDR data for ongoing practice assessment and improvements	<p>Participation in a Qualified Clinical Data Registry (QCDR) and use of QCDR data for ongoing practice assessment and improvements in patient safety, including:</p> <ul style="list-style-type: none"> • Performance of activities that promote use of standard practices, tools, and processes for quality improvement (for example, documented preventive health efforts, like screening and vaccinations) that can be shared across MIPS eligible clinicians or groups); • Use of standard questionnaires for assessing improvements in health disparities related to functional health status (for example, use of Seattle Angina Questionnaire, MD Anderson Symptom Inventory, and/or SF-12/VR-12 functional health status assessment); • Use of standardized processes for screening for drivers of health, such as food security, housing stability, and transportation accessibility; • Generation and use of regular feedback reports that summarize local practice patterns and treatment outcomes, including for populations that are disadvantaged and/or underserved by the healthcare system; • Use of processes and tools that engage patients to improve adherence to treatment plans; • Implementation of patient self-action plans; • Implementation of shared clinical decision-making capabilities; • Use of QCDR patient experience data to inform and advance improvements in beneficiary engagement; • Promotion of collaborative learning network opportunities that are interactive; • Use of supporting QCDR modules that can be incorporated into the certified EHR technology; OR • Use of QCDR data for quality improvement, such as comparative analysis across specific patient populations of adverse outcomes after an outpatient surgical procedure and corrective steps to address these outcomes. 	IA_PSPA_7	Patient Safety and Practice Assessment	Medium
Use of Patient Safety Tools	<p>In order to receive credit for this activity, a MIPS eligible clinician must use tools that assist specialty practices in tracking specific measures that are meaningful to their practice.</p> <p>Some examples of tools that could satisfy this activity are: a surgical risk calculator; evidence based protocols, such as Enhanced Recovery After Surgery (ERAS) protocols; the Centers for Disease Control (CDC) Guide for Infection Prevention for Outpatient Settings predictive algorithms; and the opiate risk tool (ORT) or similar tool.</p>	IA_PSPA_8	Patient Safety and Practice Assessment	Medium
Completion of the AMA STEPS Forward program	Completion of the American Medical Association's STEPS Forward program.	IA_PSPA_9	Patient Safety and Practice Assessment	Medium
Participation in private payer CPIA	Participation in designated private payer clinical practice improvement activities.	IA_PSPA_12	Patient Safety and Practice Assessment	Medium
Participation in Joint Commission Evaluation Initiative	Participation in Joint Commission Ongoing Professional Practice Evaluation initiative.	IA_PSPA_13	Patient Safety and Practice Assessment	Medium

Implementation of an ASP	<p>Leadership of an Antimicrobial Stewardship Program (ASP) that includes implementation of an ASP that measures the appropriate use of antibiotics for several different conditions (such as but not limited to upper respiratory infection treatment in children, diagnosis of pharyngitis, bronchitis treatment in adults) according to clinical guidelines for diagnostics and therapeutics. Specific activities may include:</p> <ul style="list-style-type: none"> • Develop facility-specific antibiogram and prepare report of findings with specific action plan that aligns with overall facility or practice strategic plan. • Lead the development, implementation, and monitoring of patient care and patient safety protocols for the delivery of ASP including protocols pertaining to the most appropriate setting for such services (i.e., outpatient or inpatient). • Assist in improving ASP service line efficiency and effectiveness by evaluating and recommending improvements in the management structure and workflow of ASP processes. • Manage compliance of the ASP policies and assist with implementation of corrective actions in accordance with facility or clinic compliance policies and hospital medical staff by-laws. • Lead the education and training of professional support staff for the purpose of maintaining an efficient and effective ASP. • Coordinate communications between ASP management and facility or practice personnel regarding activities, services, and operational/clinical protocols to achieve overall compliance and understanding of the ASP. • Assist, at the request of the facility or practice, in preparing for and responding to third-party requests, including but not limited to payer audits, governmental inquiries, and professional inquiries that pertain to the ASP service line. • Implementing and tracking an evidence-based policy or practice aimed at improving antibiotic prescribing practices for high-priority conditions. • Developing and implementing evidence-based protocols and decision-support for diagnosis and treatment of common infections. • Implementing evidence-based protocols that align with recommendations in the Centers for Disease Control and Prevention's Core Elements of Outpatient Antibiotic Stewardship guidance. 	IA_PSPA_15	Patient Safety and Practice Assessment	Medium
Use of decision support and standardized treatment protocols	Use decision support and standardized treatment protocols to manage workflow in the team to meet patient needs.	IA_PSPA_16	Patient Safety and Practice Assessment	Medium
Implementation of analytic capabilities to manage total cost of care for practice population	<p>In order to receive credit for this activity, a MIPS eligible clinician must conduct or build the capacity to conduct analytic activities to manage total cost of care for the practice population. Examples of these activities could include:</p> <ol style="list-style-type: none"> 1.) Train appropriate staff on interpretation of cost and utilization information; 2.) Use available data regularly to analyze opportunities to reduce cost through improved care. An example of a platform with the necessary analytic capability to do this is the American Society for Gastrointestinal (GI) Endoscopy's GI Operations Benchmarking Platform. 	IA_PSPA_17	Patient Safety and Practice Assessment	Medium

Measurement and improvement at the practice and panel level	<p>Measure and improve quality at the practice and panel level, such as the American Board of Orthopaedic Surgery (ABOS) Physician Scorecards that could include one or more of the following:</p> <ul style="list-style-type: none"> • Regularly review measures of quality, utilization, patient satisfaction and other measures; and/or • Use relevant data sources to create benchmarks and goals for performance at the practice or panel levels. <p>MIPS eligible clinicians can apply the measurement and quality improvement to address inequities in quality and outcomes for underserved populations, including racial, ethnic, and/or gender minorities.</p>	IA_PSPA_18	Patient Safety and Practice Assessment	Medium
Implementation of formal quality improvement methods, practice changes, or other practice improvement processes	<p>Adopt a formal model for quality improvement and create a culture in which all staff, including leadership, actively participates in improvement activities that could include one or more of the following, such as:</p> <ul style="list-style-type: none"> • Participation in multisource feedback; • Train all staff in quality improvement methods; • Integrate practice change/quality improvement into staff duties; • Engage all staff in identifying and testing practices changes; • Designate regular team meetings to review data and plan improvement cycles; • Promote transparency and accelerate improvement by sharing practice level and panel level quality of care, patient experience and utilization data with staff; • Promote transparency and engage patients and families by sharing practice level quality of care, patient experience and utilization data with patients and families, including activities in which clinicians act upon patient experience data; • Participation in Bridges to Excellence; • Participation in American Board of Medical Specialties (ABMS) Multi-Specialty Portfolio Program. 	IA_PSPA_19	Patient Safety and Practice Assessment	Medium
Implementation of fall screening and assessment programs	Implementation of fall screening and assessment programs to identify patients at risk for falls and address modifiable risk factors (e.g., Clinical decision support/prompts in the electronic health record that help manage the use of medications, such as benzodiazepines, that increase fall risk).	IA_PSPA_21	Patient Safety and Practice Assessment	Medium
CDC Training on CDC's Guideline for Prescribing Opioids for Chronic Pain	Completion of all the modules of the Centers for Disease Control and Prevention (CDC) course "Applying CDC's Guideline for Prescribing Opioids" that reviews the 2016 "Guideline for Prescribing Opioids for Chronic Pain." Note: This activity may be selected once every 4 years, to avoid duplicative information given that some of the modules may change on a year by year basis but over 4 years there would be a reasonable expectation for the set of modules to have undergone substantive change, for the improvement activities performance category score.	IA_PSPA_22	Patient Safety and Practice Assessment	High
Completion of CDC Training on Antibiotic Stewardship	Completion of all modules of the Centers for Disease Control and Prevention antibiotic stewardship course. Note: This activity may be selected once every 4 years, to avoid duplicative information given that some of the modules may change on a year by year basis but over 4 years there would be a reasonable expectation for the set of modules to have undergone substantive change, for the improvement activities performance category score.	IA_PSPA_23	Patient Safety and Practice Assessment	High
Cost Display for Laboratory and Radiographic Orders	Implementation of a cost display for laboratory and radiographic orders, such as costs that can be obtained through the Medicare clinical laboratory fee schedule.	IA_PSPA_25	Patient Safety and Practice Assessment	Medium

Communication of Unscheduled Visit for Adverse Drug Event and Nature of Event	A MIPS eligible clinician providing unscheduled care (such as an emergency room, urgent care, or other unplanned encounter) attests that, for greater than 75 percent of case visits that result from a clinically significant adverse drug event, the MIPS eligible clinician provides information, including through the use of health IT to the patient's primary care clinician regarding both the unscheduled visit and the nature of the adverse drug event within 48 hours. A clinically significant adverse event is defined as a medication-related harm or injury such as side-effects, supratherapeutic effects, allergic reactions, laboratory abnormalities, or medication errors requiring urgent/emergent evaluation, treatment, or hospitalization.	IA_PSPA_26	Patient Safety and Practice Assessment	Medium
Invasive Procedure or Surgery Anticoagulation Medication Management	For an anticoagulated patient undergoing a planned invasive procedure for which interruption in anticoagulation is anticipated, including patients taking vitamin K antagonists (warfarin), target specific oral anticoagulants (such as apixaban, dabigatran, and rivaroxaban), and heparins/low molecular weight heparins, documentation, including through the use of electronic tools, that the plan for anticoagulation management in the periprocedural period was discussed with the patient and with the clinician responsible for managing the patient's anticoagulation. Elements of the plan should include the following: discontinuation, resumption, and, if applicable, bridging, laboratory monitoring, and management of concomitant antithrombotic medications (such as antiplatelets and nonsteroidal anti-inflammatory drugs (NSAIDs)). An invasive or surgical procedure is defined as a procedure in which skin or mucous membranes and connective tissue are incised, or an instrument is introduced through a natural body orifice.	IA_PSPA_27	Patient Safety and Practice Assessment	Medium
Completion of an Accredited Safety or Quality Improvement Program	<p>Completion of an accredited performance improvement continuing medical education (CME) program that addresses performance or quality improvement according to the following criteria:</p> <ul style="list-style-type: none"> • The activity must address a quality or safety gap that is supported by a needs assessment or problem analysis, or must support the completion of such a needs assessment as part of the activity; • The activity must have specific, measurable aim(s) for improvement; • The activity must include interventions intended to result in improvement; • The activity must include data collection and analysis of performance data to assess the impact of the interventions; and • The accredited program must define meaningful clinician participation in their activity, describe the mechanism for identifying clinicians who meet the requirements, and provide participant completion information. <p>An example of an activity that could satisfy this improvement activity is completion of an accredited continuing medical education program related to opioid analgesic risk and evaluation strategy (REMS) to address pain control (that is, acute and chronic pain).</p>	IA_PSPA_28	Patient Safety and Practice Assessment	Medium

Consulting AUC Using Clinical Decision Support when Ordering Advanced	Clinicians attest that they are consulting specified applicable AUC through a qualified clinical decision support mechanism for all applicable imaging services furnished in an applicable setting, paid for under an applicable payment system, and ordered on or after January 1, 2018. This activity is for clinicians that are early adopters of the Medicare AUC program (2018 performance year) and for clinicians that begin the Medicare AUC program in future years as specified in our regulation at §414.94. The AUC program is required under section 218 of the Protecting Access to Medicare Act of 2014. Qualified mechanisms will be able to provide a report to the ordering clinician that can be used to assess patterns of image-ordering and improve upon those patterns to ensure that patients are receiving the most appropriate imaging for their individual condition.	IA_PSPA_29	Patient Safety and Practice Assessment	High
Patient Medication Risk Education	In order to receive credit for this activity, MIPS eligible clinicians must provide both written and verbal education regarding the risks of concurrent opioid and benzodiazepine use for patients who are prescribed both benzodiazepines and opioids. Education must be completed for at least 75% of qualifying patients and occur: (1) at the time of initial co-prescribing and again following greater than 6 months of co-prescribing of benzodiazepines and opioids, or (2) at least once per MIPS performance period for patients taking concurrent opioid and benzodiazepine therapy.	IA_PSPA_31	Patient Safety and Practice Assessment	High
Use of CDC Guideline for Clinical Decision Support to Prescribe Opioids for Chronic Pain via Clinical Decision Support	In order to receive credit for this activity, MIPS eligible clinicians must utilize the Centers for Disease Control (CDC) Guideline for Prescribing Opioids for Chronic Pain via clinical decision support (CDS). For CDS to be most effective, it needs to be built directly into the clinician workflow and support decision making on a specific patient at the point of care. Specific examples of how the guideline could be incorporated into a CDS workflow include, but are not limited to: electronic health record (EHR)-based prescribing prompts, order sets that require review of guidelines before prescriptions can be entered, and prompts requiring review of guidelines before a subsequent action can be taken in the record.	IA_PSPA_32	Patient Safety and Practice Assessment	High
Application of CDC's Training for Healthcare Providers on Lyme Disease	Apply the Centers for Disease Control and Prevention's (CDC) Training for Healthcare Providers on Lyme Disease using clinical decision support (CDS). CDS for Lyme disease should be built directly into the clinician workflow and support decision making for a specific patient at the point of care. Specific examples of how the guideline could be incorporated into a CDS workflow include but are not limited to: electronic health record (EHR) based prescribing prompts, order sets that require review of guidelines before prescriptions can be entered, and prompts requiring review of guidelines before a subsequent action can be taken in the record.	IA_PSPA_33	Patient Safety and Practice Assessment	Medium

Enhance Engagement of Medicaid and Other Underserved Populations	To improve responsiveness of care for Medicaid and other underserved patients: use time-to-treat data (i.e., data measuring the time between clinician identifying a need for an appointment and the patient having a scheduled appointment) to identify patterns by which care or engagement with Medicaid patients or other groups of underserved patients has not achieved standard practice guidelines; and with this information, create, implement, and monitor an approach for improvement. This approach may include screening for patient barriers to treatment, especially transportation barriers, and providing resources to improve engagement (e.g., state Medicaid non-emergency medical transportation benefit).	IA_AHE_1	Achieving Health Equity	High
Promote Use of Patient-Reported Outcome Tools	Demonstrate performance of activities for employing patient-reported outcome (PRO) tools and corresponding collection of PRO data such as the use of PHQ-2 or PHQ-9, PROMIS instruments, patient reported Wound-Quality of Life (QoL), patient reported Wound Outcome, and patient reported Nutritional Screening.	IA_AHE_3	Achieving Health Equity	High
MIPS Eligible Clinician Leadership in Clinical Trials or CBPR	Lead clinical trials, research alliances, or community-based participatory research (CBPR) that identify tools, research, or processes that focus on minimizing disparities in healthcare access, care quality, affordability, or outcomes. Research could include addressing health-related social needs like food insecurity, housing insecurity, transportation barriers, utility needs, and interpersonal safety.	IA_AHE_5	Achieving Health Equity	Medium
Provide Education Opportunities for New Clinicians	MIPS eligible clinicians acting as a preceptor for clinicians-in-training (such as medical residents/fellows, medical students, physician assistants, nurse practitioners, or clinical nurse specialists) and accepting such clinicians for clinical rotations in community practices in small, underserved, or rural areas.	IA_AHE_6	Achieving Health Equity	High

Comprehensive Eye Exams	<p>To receive credit for this activity, MIPS eligible clinicians must promote the importance of a comprehensive eye exam, which may be accomplished by any one or more of the following:</p> <ul style="list-style-type: none"> • providing literature, • facilitating a conversation about this topic using resources such as the “Think About Your Eyes” campaign, • referring patients to resources providing no-cost eye exams, such as the American Academy of Ophthalmology’s EyeCare America and the American Optometric Association’s VISION USA, or • promoting access to vision rehabilitation services as appropriate for individuals with chronic vision impairment. <p>This activity is intended for:</p> <ul style="list-style-type: none"> • Non-ophthalmologists / optometrists who refer patients to an ophthalmologist/optometrist; • Ophthalmologists/optometrists caring for underserved patients at no cost; or • Any clinician providing literature and/or resources on this topic. <p>This activity must be targeted at underserved and/or high-risk populations that would benefit from engagement regarding their eye health with the aim of improving their access to comprehensive eye exams or vision rehabilitation services.</p>	IA_AHE_7	Achieving Health Equity	Medium
Create and Implement an Anti-Racism Plan	<p>Create and implement an anti-racism plan using the CMS Disparities Impact Statement or other anti-racism planning tools. The plan should include a clinic-wide review of existing tools and policies, such as value statements or clinical practice guidelines, to ensure that they include and are aligned with a commitment to anti-racism and an understanding of race as a political and social construct, not a physiological one.</p> <p>The plan should also identify ways in which issues and gaps identified in the review can be addressed and should include target goals and milestones for addressing prioritized issues and gaps. This may also include an assessment and drafting of an organization’s plan to prevent and address racism and/or improve language access and accessibility to ensure services are accessible and understandable for those seeking care. The MIPS eligible clinician or practice can also consider including in their plan ongoing training on anti-racism and/or other processes to support identifying explicit and implicit biases in patient care and addressing historic health inequities experienced by people of color. More information about elements of the CMS Disparities Impact Statement is detailed in the template and action plan document at https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Disparities-Impact-Statement-508-rev102018.pdf.</p>	IA_AHE_8	Achieving Health Equity	High

Implement Food Insecurity and Nutrition Risk Identification and Treatment Protocols	<p>Create or improve, and then implement, protocols for identifying and providing appropriate support to: a) patients with or at risk for food insecurity, and b) patients with or at risk for poor nutritional status. (Poor nutritional status is sometimes referred to as clinical malnutrition or undernutrition and applies to people who are overweight and underweight.) Actions to implement this improvement activity may include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Use Malnutrition Quality Improvement Initiative (MQii) or other quality improvement resources and standardized screening tools to assess and improve current food insecurity and nutritional screening and care practices. • Update and use clinical decision support tools within the MIPS eligible clinician's electronic medical record to align with the new food insecurity and nutrition risk protocols. • Update and apply requirements for staff training on food security and nutrition. • Update and provide resources and referral lists, and/or engage with community partners to facilitate referrals for patients who are identified as at risk for food insecurity or poor nutritional status during screening. <p>Activities must be focused on patients at greatest risk for food insecurity and/or malnutrition—for example patients with low income who live in areas with limited access to affordable fresh food, or who are isolated or have limited mobility.</p>	IA_AHE_9	Achieving Health Equity	Medium
Adopt Certified Health Information Technology for Security Tags for Electronic Health Record Data	Use security labeling services available in certified Health Information Technology (IT) for electronic health record (EHR) data to facilitate data segmentation. Certification criteria for security tags may be found in the ONC Health IT Certification Program at 45 CFR 170.315(b)(7) and (b)(8).	IA_AHE_10	Achieving Health Equity	Medium
Create and Implement a Plan to Improve Care for Lesbian, Gay, Bisexual, Transgender, and Queer Patients	Create and implement a plan to improve care for lesbian, gay, bisexual, transgender, and queer (LGBTQ+) patients by understanding and addressing health disparities for this population. The plan may include an analysis of sexual orientation and gender identity (SO/GI) data to identify disparities in care for LGBTQ+ patients. Actions to implement this activity may also include identifying focused goals for addressing disparities in care, collecting and using patients' pronouns and chosen names, training clinicians and staff on SO/GI terminology (including as supported by certified health IT and the Office of the National Coordinator for Health Information Technology US Core Data for Interoperability [USCDI]), identifying risk factors or behaviors specific to LGBTQ+ individuals, communicating SO/GI data security and privacy practices with patients, and/or utilizing anatomical inventories when documenting patient health histories.	IA_AHE_11	Achieving Health Equity	High
Practice Improvements that Engage Community Resources to Address Drivers of Health	<p>Select and screen for drivers of health that are relevant for the eligible clinician's population using evidence-based tools. If possible, use a screening tool that is health IT-enabled and includes standards-based, coded questions/fields for the capture of data. After screening, address identified drivers of health through at least one of the following:</p> <ul style="list-style-type: none"> • Develop and maintain formal relationships with community-based organizations to strengthen the community service referral process, implementing closed-loop referrals where feasible; or • Work with community partners to provide and/or update a community resource guide for to patients who are found to have and/or be at risk in one or more areas of drivers 	IA_AHE_12	Achieving Health Equity	High

	<p>of health; or</p> <ul style="list-style-type: none"> Record findings of screening and follow up within the electronic health record (EHR); identify screened patients with one or more needs associated with drivers of health and implement approaches to better serve their holistic needs through meaningful linkages to community resources. <p>Drivers of health (also referred to as social determinants of health [SDOH] or health-related social needs [HSRN]) prioritized by the practice might include, but are not limited to, the following: food security; housing stability; transportation accessibility; interpersonal safety; legal challenges; and environmental exposures.</p>			
Participation on Disaster Medical Assistance Team, registered for 6 months	Participation in Disaster Medical Assistance Teams, or Community Emergency Responder Teams. Activities that simply involve registration are not sufficient. MIPS eligible clinicians and MIPS eligible clinician groups must be registered for a minimum of 6 months as a volunteer for disaster or emergency response.	IA_ERP_1	Emergency Response And Preparedness	Medium
Participation in a 60-day or greater effort to support domestic or international humanitarian needs	Participation in domestic or international humanitarian volunteer work. Activities that simply involve registration are not sufficient. MIPS eligible clinicians and groups attest to domestic or international humanitarian volunteer work for a period of a continuous 60 days or greater.	IA_ERP_2	Emergency Response And Preparedness	High
COVID-19 Clinical Data Reporting with or without Clinical Trial	<p>To receive credit for this improvement activity, a MIPS eligible clinician or group must: (1) participate in a COVID-19 clinical trial utilizing a drug or biological product to treat a patient with a COVID-19 infection and report their findings through a clinical data repository or clinical data registry for the duration of their study; or (2) participate in the care of patients diagnosed with COVID-19 and simultaneously submit relevant clinical data to a clinical data registry for ongoing or future COVID-19 research. Data would be submitted to the extent permitted by applicable privacy and security laws. Examples of COVID-19 clinical trials may be found on the U.S. National Library of Medicine website at https://clinicaltrials.gov/ct2/results?cond=COVID-19. In addition, examples of COVID-19 clinical data registries may be found on the National Institute of Health website at https://search.nih.gov/search?utf8=%E2%9C%93&affiliate=nih&query=COVID19+registries&commit=Search.</p> <p>For purposes of this improvement activity, clinical data registries must meet the following requirements: (1) the receiving entity must declare that they are ready to accept data as a clinical registry; and (2) be using the data to improve population health outcomes. Most public health agencies and clinical data registries declare readiness to accept data from clinicians via a public online posting. Clinical data registries should make publically available specific information on what data the registry gathers, technical requirements or specifications for how the registry can receive the data, and how the registry may use, re-use, or disclose individually identifiable data it receives. For purposes of credit toward this improvement activity, any data should be sent to the clinical data registry in a structured format, which the registry is capable of receiving. A MIPS-eligible clinician may submit the data using any standard or format that is supported by the clinician's health IT systems, including but not limited to, certified functions within those systems. Such methods may include,</p>	IA_ERP_3	Emergency Response And Preparedness	High

	but are not limited to, a secure upload function on a web portal, or submission via an intermediary, such as a health information exchange. To ensure interoperability and versatility of the data submitted, any electronic data should be submitted to the clinical data registry using appropriate vocabulary standards for the specific data elements, such as those identified in the United States Core Data for Interoperability (USCDI) standard adopted in 45 CFR 170.213.			
Implementation of a Personal Protective Equipment (PPE) Plan	<p>Implement a plan to acquire, store, maintain, and replenish supplies of personal protective equipment (PPE) for all clinicians or other staff who are in physical proximity to patients.</p> <p>In accordance with guidance from the Centers for Disease Control and Prevention (CDC) the PPE plan should address:</p> <ul style="list-style-type: none"> • Conventional capacity: PPE controls that should be implemented in general infection prevention and control plans in healthcare settings, including training in proper PPE use. • Contingency capacity: actions that may be used temporarily during periods of expected PPE shortages. • Crisis capacity: strategies that may need to be considered during periods of known PPE shortages. <p>The PPE plan should address all of the following types of PPE:</p> <ul style="list-style-type: none"> • Standard precautions (e.g., hand hygiene, prevention of needle-stick or sharps injuries, safe waste management, cleaning and disinfection of the environment) • Eye protection • Gowns (including coveralls or aprons) • Gloves • Facemasks • Respirators (including N95 respirators) 	IA_ERP_4	Emergency Response And Preparedness	Medium

Implementation of a Laboratory Preparedness Plan	Develop, implement, update, and maintain a preparedness plan for a laboratory intended to support continued or expanded patient care during COVID-19 or another public health emergency. The plan should address how the laboratory would maintain or expand patient access to health care services to improve beneficiary health outcomes and reduce healthcare disparities. For laboratories without a preparedness plan, MIPS eligible clinicians would meet with stakeholders, record minutes, and document a preparedness plan, as needed. The laboratory must then implement the steps identified in the plan and maintain them. For laboratories with existing preparedness plans, MIPS eligible clinicians should review, revise, or update the plan as necessary to meet the needs of the current PHE, implement new procedures, and maintain the plan. Maintenance of the plan in this activity could include additional hazard assessments, drills, training, and/or developing checklists to facilitate execution of the plan. Participation in debriefings to evaluate the effectiveness of plans are additional examples of engagement in this activity.	IA_ERP_5	Emergency Response And Preparedness	Medium
COVID-19 Vaccine Achievement for Practice Staff	Demonstrate that the MIPS eligible clinician's practice has maintained or achieved a rate of 100% of office staff staying up to date with COVID vaccines according to the Centers for Disease Control and Prevention (https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html). Please note that those who are determined to have a medical contraindication specified by CDC recommendations are excluded from this activity.	IA_ERP_6	Emergency Response and Preparedness	Medium
Diabetes screening	Diabetes screening for people with schizophrenia or bipolar disease who are using antipsychotic medication.	IA_BMH_1	Behavioral And Mental Health	Medium
Tobacco use	Tobacco use: Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including tobacco use screening and cessation interventions (refer to NQF #0028) for patients with co-occurring conditions of behavioral or mental health and at risk factors for tobacco dependence.	IA_BMH_2	Behavioral And Mental Health	Medium
Depression screening	Depression screening and follow-up plan: Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including depression screening and follow-up plan (refer to NQF #0418) for patients with co-occurring conditions of behavioral or mental health conditions.	IA_BMH_4	Behavioral And Mental Health	Medium
MDD prevention and treatment interventions	Major depressive disorder: Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including suicide risk assessment (refer to NQF #0104) for mental health patients with co-occurring conditions of behavioral or mental health conditions.	IA_BMH_5	Behavioral And Mental Health	Medium
Implementation of co-location PCP and MH services	Integration facilitation and promotion of the colocation of mental health and substance use disorder services in primary and/or non-primary clinical care settings.	IA_BMH_6	Behavioral And Mental Health	High

Implementation of Integrated Patient Centered Behavioral Health Model	<p>Offer integrated behavioral health services to support patients with behavioral health needs who also have conditions such as dementia or other poorly controlled chronic illnesses. The services could include one or more of the following:</p> <ul style="list-style-type: none"> • Use evidence-based treatment protocols and treatment to goal where appropriate; • Use evidence-based screening and case finding strategies to identify individuals at risk and in need of services; • Ensure regular communication and coordinated workflows between MIPS eligible clinicians in primary care and behavioral health; • Conduct regular case reviews for at-risk or unstable patients and those who are not responding to treatment; • Use of a registry or health information technology functionality to support active care management and outreach to patients in treatment; • Integrate behavioral health and medical care plans and facilitate integration through co-location of services when feasible; and/or • Participate in the National Partnership to Improve Dementia Care Initiative, which promotes a multidimensional approach that includes public reporting, state-based coalitions, research, training, and revised surveyor guidance. 	IA_BMH_7	Behavioral And Mental Health	High
Electronic Health Record Enhancements for BH data capture	Enhancements to an electronic health record to capture additional data on behavioral health (BH) populations and use that data for additional decision-making purposes (e.g., capture of additional BH data results in additional depression screening for at-risk patient not previously identified).	IA_BMH_8	Behavioral And Mental Health	Medium
Unhealthy Alcohol Use for Patients with Co-occurring Conditions of Mental Health and Substance Abuse and Ambulatory Care Patients	Individual MIPS eligible clinicians or groups must regularly engage in integrated prevention and treatment interventions, including screening and brief counseling (for example: NQF #2152) for patients with co-occurring conditions of mental health and substance abuse. MIPS eligible clinicians would attest that 60 percent for the CY 2018 Quality Payment Program performance period, and 75 percent beginning in the 2019 performance period, of their ambulatory care patients are screened for unhealthy alcohol use.	IA_BMH_9	Behavioral And Mental Health	High
Completion of Collaborative Care Management Training Program	To receive credit for this activity, MIPS eligible clinicians must complete a collaborative care management training program, such as the American Psychiatric Association (APA) Collaborative Care Model training program available to the public, in order to implement a collaborative care management approach that provides comprehensive training in the integration of behavioral health into the primary care practice.	IA_BMH_10	Behavioral And Mental Health	Medium

Implementation of a Trauma-Informed Care (TIC) Approach to Clinical Practice	<p>Create and implement a plan for trauma-informed care (TIC) that recognizes the potential impact of trauma experiences on patients and takes steps to mitigate the effects of adverse events in order to avoid re-traumatizing or triggering past trauma. Actions in this plan may include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Incorporate trauma-informed training into new employee orientation • Offer annual refreshers and/or trainings for all staff • Recommend and supply TIC materials to third party partners, including care management companies and billing services • Identify patients using a screening methodology • Flag charts for patients with one or more adverse events that might have caused trauma • Use ICD-10 diagnosis codes for adverse events when appropriate <p>TIC is a strengths-based healthcare delivery approach that emphasizes physical, psychological, and emotional safety for both trauma survivors and their providers. Core components of a TIC approach are: awareness of the prevalence of trauma; understanding of the impact of past trauma on services utilization and engagement; and a commitment and plan to incorporate that understanding into training, policy, procedure, and practice.</p>	IA_BMH_11	Behavioral And Mental Health	Medium
Promoting Clinician Well-Being	<p>Develop and implement programs to support clinician well-being and resilience—for example, through relationship-building opportunities, leadership development plans, or creation of a team within a practice to address clinician well-being—using one of the following approaches:</p> <ul style="list-style-type: none"> • Completion of clinician survey on clinician well-being with subsequent implementation of an improvement plan based on the results of the survey. • Completion of training regarding clinician well-being with subsequent implementation of a plan for improvement. 	IA_BMH_12	Behavioral And Mental Health	High
Obtain or Renew an Approved Waiver for Provision of Buprenorphine as Medication-Assisted Treatment for Opioid Use Disorder	Complete any required training and obtain or renew an approved waiver for provision of medication-assisted treatment of opioid use disorders using buprenorphine. Note: This activity may be selected once for low-capacity waivers, as these do not expire, and once every 3 years for the expanded waiver, in keeping with renewal requirements.	IA_BMH_13	Behavioral and Mental Health	Medium
Electronic submission of Patient Centered Medical Home accreditation	N/A	IA_PCMH		

Version History

Date	Change Description
12/30/2022	Original version.

Quality Payment PROGRAM

2023 MIPS Data Validation – Improvement Activities Performance Category Criteria

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
NOTE: Eligible clinicians are encouraged to explore the Inventory and complete different activities over time, rather than reporting the same activities year after year						
IA_EPA_1	Expanded Practice Access	Provide 24/7 Access to MIPS Eligible Clinicians or Groups Who Have Real-Time Access to Patient's Medical Record	<p>Provide 24/7 access to MIPS eligible clinicians, groups, or care teams for advice about urgent care (e.g., MIPS eligible clinician and care team access to medical record, cross-coverage with access to medical record, or protocol-driven nurse line with access to medical record) that could include one or more of the following:</p> <ul style="list-style-type: none"> Expanded hours in evenings and weekends with access to the patient medical record (e.g., coordinate with small practices to provide alternate hour office visits and urgent care); Use of alternatives to increase access to care team by MIPS eligible clinicians and groups, such as e-visits, phone visits, group 	High	<p>Objective: Increase patient access to eligible clinicians who work in an outpatient setting with the goal of reducing unnecessary emergency room visits.</p> <p>Validation Documentation: Evidence of demonstrated patient care provided outside of normal business hours through expanded practice hours and by eligible clinicians with real-time access to patient's electronic health record (EHR), or that patients received needed urgent care in a timely way. Expanded Business Hours are defined as hours that are outside of a practice's standard business hours of operation. Include at least one of the following elements:</p> <p>1) Patient record from EHR – A patient record from an EHR with date and timestamp indicating services provided outside of the practice's normal business hours for that eligible clinician (a certified EHR may be used for documentation purposes, but is not required unless attesting for the Promoting Interoperability bonus); OR</p>	2017



ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
			visits, home visits and alternate locations (e.g., senior centers and assisted living centers); and/or <ul style="list-style-type: none"> • Provision of same-day or next-day access to a MIPS eligible clinician, group or care team when needed for urgent care or transition management. 		2) Patient encounter/medical record/claim – Patient encounter/medical record/claim indicating patient was seen or services provided outside of the practice’s normal business hours for that eligible clinician, including use of telehealth visits, or that the services were provided at an alternative location (e.g., senior centers, assisted living centers, centers for independent living, area agencies on aging); OR 3) Same or next-day patient encounter/medical record/claim – Patient encounter/medical record/claim indicating patient was seen same-day or next-day by an eligible clinician or practice for urgent care or transition management.	
IA_EPA_2	Expanded Practice Access	Use of telehealth services that expand practice access	Create and implement a standardized process for providing telehealth services to expand access to care.	Medium	<p><u>Objective:</u> Improve health outcomes by expanding patient access to telehealth services that are delivered through standardized processes.</p> <p><u>Validation Documentation:</u> Evidence of the creation and implementation of standardized processes for providing telehealth services. Telehealth services may include care provided over the phone, online, etc., and are not limited to the Medicare-reimbursed telehealth service criteria. Include both of the following elements:</p> <p>1) Standardized processes – Creation of standardized processes for the provision of telehealth services.</p>	2017

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
					<p>Examples of documentation include a) description of standardized telehealth processes in an eligible clinician or practice procedures manual; b) workflow diagrams depicting standardized telehealth processes used regularly by an eligible clinician or practice; AND 2) Implementation documentation – Implementation of standardized processes for providing telehealth services. Examples of documentation include a) claims adjudication (may use G-codes to validate); b) electronic health record (EHR); or c) other medical record document showing specific telehealth services, consults, or referrals performed for a patient in accordance with standardized processes.</p> <p><u>Information:</u> How to get or provide remote health care website provides best practices for clinicians looking to improve their telehealth services: https://telehealth.hhs.gov/</p>	
IA_EPA_3	Expanded Practice Access	Collection and use of patient experience and satisfaction data on access	Collection of patient experience and satisfaction data on access to care and development of an improvement plan, such as outlining steps for improving communications with patients to help understanding of urgent access needs.	Medium	<p><u>Objective:</u> Develop an improvement plan informed by patient experience and satisfaction data, including any differences across demographic groups, so that eligible clinicians can use data-driven approaches to improve patient access and quality of care.</p> <p><u>Validation Documentation:</u> Evidence of documented improvement plan for access to care and quality based</p>	2017

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					<p>on collected and stratified patient experience and satisfaction data. The goals for improvement can be defined broadly or within certain population strata. CMS examples of stratification may include patient demographics such as race/ethnicity, disability status, sexual orientation, sex, gender identity, or geography. (It is acknowledged that some stratification data may not be available). Include both of the following elements:</p> <p>1) Patient experience and satisfaction data on access to care – Data collected through a patient experience survey for a population defined by the eligible clinician. For example, eligible clinicians could give the survey to all patients seen within a defined study period. Data can be prepared in any useful format, or as they were collected; AND</p> <p>2) Improvement plan – Documentation of an improvement plan, which should include specific activities, goals, and outcomes for addressing access to care. For example, an eligible clinician may observe that non-English-speaking patients were not confident in their interactions with eligible clinicians because of language barriers. A possible plan could include using translators, remote translation services, or language training. The improvement plan would include details</p>	

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					regarding who would be trained with timelines for completion.	
IA_EPA_4	Expanded Practice Access	Additional improvements in access as a result of QIN/QIO TA	As a result of Quality Innovation Network-Quality Improvement Organization technical assistance, performance of additional activities that improve access to services or improve care coordination (for example, investment of on-site diabetes educator).	Medium	<p><u>Objective:</u> Use learnings from engagement with Quality Innovation Network-Quality Improvement Organization (QIN-QIO) technical assistance to design, plan, and initiate implementation of new activities, ultimately improving access to services or care coordination.</p> <p><u>Validation Documentation:</u> Evidence of implementation of newly added processes, practices, resources, or technology to improve access to services or improve care coordination as a result of receiving QIN-QIO technical assistance. Include both of the following elements:</p> <p>1) Relationship with QIN-QIO technical assistance – Confirmation of technical assistance and documentation of relationship with QIN-QIO (e.g., signed letter of agreement, email exchange); AND</p> <p>2) Activities – Documentation of planned and/or tested activities that improve access or improve care coordination, including support for newly offered services.</p>	2017

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IA_EPA_5	Expanded Practice Access	Participation in User Testing of the Quality Payment Program Website (https://qpp.cms.gov/)	User participation in the Quality Payment Program website testing is an activity for eligible clinicians who have worked with CMS to provide substantive, timely, and responsive input to improve the CMS Quality Payment Program website through product user-testing that enhances system and program accessibility, readability and responsiveness as well as providing feedback for developing tools and guidance thereby allowing for a more user-friendly and accessible clinician and practice Quality Payment Program website experience.	Medium	<p>Objective: Help CMS improve the content provided on the Quality Payment Program (QPP) website.</p> <p>Validation Documentation: Evidence of user participation and implementation of website testing for the QPP. Eligible clinicians must be verified on CMS User/Tester list and be able to share at least one of the following elements:</p> <p>1) Improvement input – Documentation of specific input to improve the CMS QPP website through product user-testing aimed at enhancing system and program accessibility, readability, and responsiveness (e.g., saved emails, Word document with notes); OR</p> <p>2) Tool/guidance development feedback – Documentation of specific feedback for developing tools and guidance for a more efficient and accessible clinician and practice QPP website experience (e.g., saved emails, Word document with notes).</p> <p>Information: Office staff, either clinical or non-clinical, can participate/attest on behalf of a MIPS eligible clinician in order to receive improvement activity credit as long as they are working with the permission and oversight of the eligible clinician. This means the credit may only be applied to a single eligible clinician responsible for granting permission and overseeing</p>	2018

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					the authorized staff member. If the staff member participates in an activity that meets the criteria for the credit, it cannot be applied to all eligible clinicians within a Taxpayer Identification Number (TIN). If the clinician is in a group, the approved representative should only provide input for 1 clinician per User Testing session. In addition, at least 50% of a group's National Provider Identifiers (NPIs) must perform the same activity for a continuous 90 days in the performance period beginning with the 2020 performance year. This means that 50% of the clinicians (NPIs) must complete an improvement activity in order for the entire group (TIN) to receive credit in the improvement activities category. However, it is important to note that clinicians in the group do not have to perform the same improvement activity in the same 90 days.	
IA_EPA_6	Expanded Practice Access	Create and Implement a Language Access Plan	Create and implement a language access plan to address communication barriers for individuals with limited English proficiency. The language access plan must align with standards for communication and language assistance defined in the National Standards for Culturally and	High	<p><u>Objective:</u> Improve quality of care and patient outcomes by ensuring clear and culturally relevant communication with patients with limited English proficiency.</p> <p><u>Validation Documentation:</u> Evidence of a practice-wide review and implementation of a plan to language access.</p>	2023

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			Linguistically Appropriate Services (CLAS) in Health and Health Care (https://thinkculturalhealth.hhs.gov/clas).		<p>1) Review - Documentation of a practice-wide review of existing tools and policies; AND</p> <p>2) Gap analysis memo - Completion of a memo comparing the results of the above review with the four standards on communication and language assistance stipulated in the National CLAS Standards; AND</p> <p>3) Plan to improve language access - A new or updated plan, which includes information on patient needs (i.e., common languages spoken, percent of practice's population that has low English proficiency), defines how interpretation will be provided, outlines how patients and families will be notified about interpretation services, and specifies staff training; AND</p> <p>4) Plan Implementation - Report comparing the results from implementing the new or updated language access plan with the four standards on communication and language assistance stipulated in the National CLAS Standards and documenting where gaps have been closed or still remain.</p> <p><u>Example(s)</u>: A practice-wide review and gap analysis indicated that a practice's signage and website is predominantly in English only and that clinicians often rely on family members to communicate with patients</p>	

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					<p>with limited English proficiency. The practice updated its signage and website to include common languages other than English and make patients aware that interpretation services are available at no cost. The clinic trained clinicians on use of professional interpreter services.</p> <p><u>Information:</u></p> <ul style="list-style-type: none"> • The U.S. Department of Health and Human Services publishes the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. Four of these standards address communication and language assistance. Free, continuing education e-learning programs are available for clinicians, allied health workers, and administrators. National Standards for Culturally and Linguistically Appropriate Services. (https://thinkculturalhealth.hhs.gov/clas) • CMS has issued a Guide to Developing a Language Access Plan that identifies ways that providers can assess their programs and develop language access plans to ensure persons with limited English proficiency have meaningful access to their programs: Guide to Developing a Language Access Plan. (https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Language-Access- 	

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					<p>Plan.pdf)</p> <ul style="list-style-type: none"> This 2017 article by Alexander R. Green and Chijioke Nze uses a case vignette to illustrate the potentially serious consequences of language barriers for the care of patients with limited English proficiency, and suggests actions that can be taken to improve patient care: Language-Based Inequity in Health Care: Who Is the “Poor Historian”? AMA J Ethics. 2017;19(3):263-271. doi: 10.1001/journalofethics.2017.19.3.medu1-1703. (https://journalofethics.ama-assn.org/article/language-based-inequity-health-care-who-poor-historian/2017-03) 	
IA_PM_2	Population Management	Anticoagulant management improvements	Individual MIPS eligible clinicians and groups who prescribe anti-coagulation medications (including, but not limited to oral Vitamin K antagonist therapy, including warfarin or other coagulation cascade inhibitors) must attest that for 75 percent of their ambulatory care patients receiving these medications are being managed with support from one or more of the following improvement activities:	High	<p><u>Objective:</u> Improve patient understanding and adherence while reducing the risk of medication errors and adverse drug events.</p> <p><u>Validation Documentation:</u> Evidence of participation by patients who have anti-coagulation medication prescriptions in one or more of the clinical practice improvement activities listed in the Activity Description. Include all of the following elements:</p> <p>1) Patients receiving anti-coagulation medications – Total number of outpatients prescribed oral Vitamin K antagonist therapy (e.g., claims, electronic health record report); AND</p>	2017

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			<ul style="list-style-type: none"> • Participation in a systematic anticoagulation program (coagulation clinic, patient self-reporting program, or patient self-management program); • Patients are being managed by an anticoagulant management service, that involves systematic and coordinated care, incorporating comprehensive patient education, systematic prothrombin time (PT-INR) testing, tracking, follow-up, and patient communication of results and dosing decisions; • Patients are being managed according to validated electronic decision support and clinical management tools that involve systematic and coordinated care, incorporating comprehensive patient education, systematic PT-INR testing, tracking, follow-up, and patient communication of results and dosing decisions; • For rural or remote patients, patients are managed using remote 		<p>2) Percentage of that total being managed by one of the methods of care in the Activity Description – Number of outpatients prescribed oral Vitamin K antagonist therapy and who are being managed by one or more of the four activities in the Activity Description; AND</p> <p>3) Patient-centered plan – Documentation that the plan addresses patients' language and communication needs, literacy level, and cognitive and functional limitations.</p>	

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
			<p>monitoring or telehealth options that involve systematic and coordinated care, incorporating comprehensive patient education, systematic PT-INR testing, tracking, follow-up, and patient communication of results and dosing decisions; or</p> <ul style="list-style-type: none"> • For patients who demonstrate motivation, competency, and adherence, patients are managed using either a patient self-testing (PST) or patient-self-management (PSM) program. 			
IA_PM_3	Population Management	RHC, IHS or FQHC quality improvement activities	<p>Participating in a Rural Health Clinic (RHC), Indian Health Service Medium Management (IHS), or Federally Qualified Health Center in ongoing engagement activities that contribute to more formal quality reporting, and that include receiving quality data back for broader quality improvement and benchmarking improvement which will ultimately benefit patients. Participation in Indian Health</p>	High	<p><u>Objective:</u> Improve quality of care and formal quality improvement and reporting for Native Americans, Alaskan Natives, populations served by Rural Health Clinics (RHC), and Federally Qualified Health Centers (FQHC).</p> <p><u>Validation Documentation:</u> Evidence of quality improvement activity participation as part of RHC, Indian Health Service (HIS), or FQHC participation. By vulnerable populations/patients, CMS is referring to racial and ethnic minorities, refugees, those who are elderly, financially disadvantaged, or without health</p>	2017

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			Service, as an improvement activity, requires MIPS eligible clinicians and groups to deliver care to federally recognized American Indian and Alaska Native populations in the U.S. and in the course of that care implement continuous clinical practice improvement including reporting data on quality of services being provided and receiving feedback to make improvements over time.		<p>insurance, and those who have a disability or medical condition which are associated with disparities in outcomes across populations. Include both of the following elements:</p> <p>1) Name of RHC, IHS or FQHC – Identified name of RHC, IHS, or FQHC in which the eligible clinician participates in ongoing engagement activities; AND</p> <p>2) Continuous quality improvement activities - Documented continuous quality improvement activities aimed at services provided to RHC, IHS, or FQHC patients. To the extent possible, these quality improvement activities should contribute to more formal quality reporting, and should include receiving quality data back for broader quality and benchmarking improvement (e.g., data reports or dashboards tied to quality improvement projects).</p>	
IA_PM_4	Population Management	Glycemic management services	<p>For outpatient Medicare beneficiaries with diabetes and who are prescribed antidiabetic agents (e.g., insulin, sulfonylureas), MIPS eligible clinicians and groups must attest to having:</p> <p>For the first performance year, at least 60 percent of medical records</p>	High	<p><u>Objective:</u> Improve diabetes care by defining and documenting individualize glycemic control goals.</p> <p><u>Validation Documentation:</u> Evidence of report identifying diabetic patients who are taking diabetes medication and have documented glycemic treatment goals based on patient-specific factors. Include all of the following elements:</p>	2017

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			<p>with documentation of an individualized glycemic treatment goal that:</p> <p>a) Takes into account patient-specific factors, including, at least 1) age, 2) comorbidities, and 3) risk for hypoglycemia, and</p> <p>b) Is reassessed at least annually.</p> <p>The performance threshold will increase to 75 percent for the second performance year and onward.</p> <p>Clinician would attest that, 60 percent for first year, or 75 percent for the second year, of their medical records that document individualized glycemic treatment represent patients who are being treated for at least 90 days during the performance period.</p>		<p>1) Diabetic patients prescribed antidiabetic agents – Total number of outpatients who are diabetic and prescribed antidiabetic agents; AND</p> <p>2) Percentage of that total with glycemic treatment goals – Percentage of outpatient Medicare beneficiaries, who are diabetic and prescribed antidiabetic agents, with documented glycemic treatment goals. The goals must encompass patient-specific factors, including at least: a) age, b) comorbidities, and c) risk for hypoglycemia; AND</p> <p>3) Annual assessment – Documented evidence of annual assessment for patients receiving glycemic treatment services (e.g., list of patients flagged for reassessment the following year, dated chart notes in an electronic health record).</p> <p><u>Information:</u></p> <ul style="list-style-type: none"> • A catalog of diabetes prevention resources tailored to various audiences, including racial and ethnic minorities, lesbian, gay, bisexual, transgender, queer and others (LGBTQ+) communities, people with disabilities, and people with limited English proficiency: <p>https://www.cms.gov/files/document/culturally-and-linguistically-tailored-type-2-diabetes-prevention-</p>	

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					resource.pdf <ul style="list-style-type: none"> • Provider Directory to facilitate diabetes treatment for primary care teams, particularly providers working with Medicare beneficiaries and vulnerable populations who experience a higher prevalence of type 2 diabetes and its complications: https://www.cms.gov/files/document/diabetes-provider-resource-directory.pdf 	
IA_PM_5	Population Management	Engagement of community for health status improvement	Take steps to improve health status of communities, such as collaborating with key partners and stakeholders to implement evidenced-based practices to improve a specific chronic condition. Refer to the local Quality Improvement Organization (QIO) for additional steps to take for improving health status of communities as there are many steps to select from for satisfying this activity. QIOs work under the direction of CMS to assist MIPS eligible clinicians and groups with quality improvement, and review quality concerns for the protection	Medium	<p><u>Objective:</u> Improve specific chronic condition health outcomes for community populations served by an eligible clinician or practice by implementing evidence-based practices and partnership with a Quality Improvement Organization (QIO).</p> <p><u>Validation Documentation:</u> Evidence of implementation of activity to improve specific chronic condition (e.g., diabetes, chronic kidney disease, hypertension) for specific identified population within the community. Include both of the following elements:</p> <p>1) Documentation of partnership in the community – Screenshot of QIO website or other correspondence that identifies your organization as one of the key partners and stakeholders and that lists the activity that will be implemented, with details on the specific chronic condition and population targeted; AND</p>	2017

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			of beneficiaries and the Medicare Trust Fund.		2) Plan for improving community health – QIO report, document, or correspondence detailing steps being taken to satisfy the activity. May include: timeline, purpose, anticipated outcome(s), and relevant tools (e.g., Population Health Toolkit).	
IA_PM_6	Population Management	Use of toolsets or other resources to close healthcare disparities across communities	Address inequities in health outcomes by using population health data analysis tools to identify health inequities in the community and practice and assess options for effective and relevant interventions such as Population Health Toolkit or other resources identified by the clinician, practice, or by CMS. Based on this information, create, refine, and implement an action plan to address and close inequities in health outcomes and/or health care access, quality, and safety.	Medium	<p><u>Objective:</u> Decrease healthcare inequities and improve health status in underserved communities.</p> <p><u>Validation Documentation:</u> Evidence of activity to decrease healthcare inequities. Include both of the following elements:</p> <p>1) Population health data analysis resources used – Documentation of resources used to identify health inequities in the practice's population and to assess options for intervention; AND</p> <p>2) Implementation report – Report with action plan for implementing the selected intervention (including the health inequity targeted, detailed plan for improvement, and the specific outcomes targeted for improvement), and results from its implementation.</p> <p><u>Example(s):</u></p> <ul style="list-style-type: none"> • National Rural Health Resource Center Population Health Toolkit: https://www.ruralcenter.org/population-health-toolkit 	2017

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					<ul style="list-style-type: none"> • CMS Network of Quality Improvement and Innovation Contractor (NQIIC) program health equity resource page: https://qi.ipro.org/health-equity/; • Novartis Foundation Urban Population Health Toolkit (cardiovascular disease focus): https://www.novartisfoundation.org/urban-population-health-toolkit 	
IA_PM_11	Population Management	Regular review practices in place on targeted patient population needs	Implement regular reviews of targeted patient population needs, such as structured clinical case reviews, which include access to reports that show unique characteristics of MIPS eligible clinician's patient population, identification of underserved patients, and how clinical treatment needs are being tailored, if necessary, to address unique needs and what resources in the community have been identified as additional resources. The review should consider how structural inequities, such as racism, are influencing patterns of care and consider changes to acknowledge	Medium	<p><u>Objective:</u> Improve understanding of targeted populations' unique needs to tailor clinical treatments, address structural inequities, and better utilize community resources.</p> <p><u>Validation Documentation:</u> Evidence of participation in identification and reviews of targeted patient population needs. Include all of the following elements:</p> <p>1) Targeted patient population identification – Documentation of method/s for identification and ongoing monitoring of a targeted patient population (e.g., policy or protocol), including stratification of patient data by demographic characteristics and, as needed, health-related social needs to appropriately identify differences among populations and assess drivers of gaps and inequities, as well as identifying interventions appropriate for the needs the targeted</p>	2017

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			and address them. Reviews should stratify patient data by demographic characteristics and health related social needs to appropriately identify differences among unique populations and assess the drivers of gaps and disparities and identify interventions appropriate for the needs of the sub-populations.		<p>population; AND</p> <p>2) Review of targeted population's unique characteristics and needs – Report that compiles information on the unique characteristics of the targeted patient population, including inequities in relevant outcomes; ways to tailor clinical treatments to meet needs and reduce inequities (e.g., clinicians treating Black men, who have a higher incidence of prostate cancer, may choose to evaluate that population for consistency of screening); and lists of community resources that can further support patients with these needs outside of the clinical setting; AND</p> <p>3) Implementation Report – Report with action plan detailing steps the practice has taken to address the results of its targeted population identification and needs assessment.</p> <p><u>Information:</u></p> <ul style="list-style-type: none"> • Health-related social needs (HRSN) screening tools that meet the recommended criteria for this activity include: <ul style="list-style-type: none"> o The Centers for Medicare & Medicaid Services' Accountable Health Communities screening tool: https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf. 	

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					<ul style="list-style-type: none"> o National Association of Community Health Centers' Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) assessment: https://www.nachc.org/wp-content/uploads/2020/04/PRAPARE-One-Pager-9-2-16-with-logo-and-trademark.pdf o Health Lead's Screening Tool: https://healthleadsusa.org/resources/the-health-leads-screening-toolkit/ <ul style="list-style-type: none"> • Background on identifying and addressing health-related social needs at primary care settings: https://www.ahrq.gov/sites/default/files/wysiwyg/evidence/now/tools-and-materials/social-needs-tool.pdf. 	
IA_PM_12	Population Management	Population empanelment	<p>Empanel (assign responsibility for) the total population, linking each patient to a MIPS eligible clinician or group or care team.</p> <p>Empanelment is a series of processes that assign each active patient to a MIPS eligible clinician or group and/or care team, confirm assignment with patients and clinicians, and use the resultant patient panels as a foundation for individual patient and population</p>	Medium	<p><u>Objective:</u> Strengthen patient-clinician relationships, making it possible to provide comprehensive, patient-centered primary care.</p> <p><u>Validation Documentation:</u> Evidence of patient population empanelment including use of panels for health management. Include both of the following elements:</p> <p>1) Active population empanelment – Identification and selected operational definition of "active population" of the practice with empanelment and assignment confirmation linking patients to eligible clinician or care team (e.g., electronic health record</p>	2017

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			<p>health management.</p> <p>Empanelment identifies the patients and population for whom the MIPS eligible clinician or group and/or care team is responsible and is the foundation for the relationship continuity between patient and MIPS eligible clinician or group /care team that is at the heart of comprehensive primary care. Effective empanelment requires identification of the “active population” of the practice: those patients who identify and use your practice as a source for primary care. There are many ways to define “active patients” operationally, but generally, the definition of “active patients” includes patients who have sought care within the last 24 to 36 months, allowing inclusion of younger patients who have minimal acute or preventive health care.</p>		<p>report, Excel document); AND</p> <p>2) Process for updating panel – Documented policy and/or process for review and update of panel assignments (e.g., detailed policy about frequency of review, stepwise guidance document for how to empanel new patients or reassign existing patients).</p>	

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IA_PM_13	Population Management	Chronic care and preventative care management for empaneled patients	<p>In order to receive credit for this activity, a MIPS eligible clinician must manage chronic and preventive care for empaneled patients (that is, patients assigned to care teams for the purpose of population health management), which could include one or more of the following actions:</p> <ul style="list-style-type: none"> • Provide patients annually with an opportunity for development and/or adjustment of an individualized plan of care as appropriate to age and health status, including health risk appraisal; gender, age and condition-specific preventive care services; and plan of care for chronic conditions; • Use evidence based, condition-specific pathways for care of chronic conditions (for example, hypertension, diabetes, depression, asthma, and heart failure). These might include, but are not limited to, the NCQA Diabetes Recognition 	Medium	<p><u>Objective:</u> Improve effectiveness, efficiency, and patient-centeredness of preventive and chronic care provided to empaneled patients.</p> <p><u>Validation Documentation:</u> Evidence of chronic and preventative care management for empaneled patients via an individualized plan of care as appropriate to age and health status, including a) health risk appraisal; b) gender, age, and condition-specific preventive care services (e.g., managing cardiovascular risk in patients with diabetes); and c) plan of care for chronic conditions (could use electronic health record [EHR] or medical records). Include at least one of the following elements:</p> <p>1) Individualized plan of care – Documented indication of annual opportunity for development and/or adjustment of an individualized plan of care appropriate to age and health status (e.g., EHR alert or dated medical record note). Plan of care may include disease-specific services, such as Diabetes Self-Management Education and Support (DSME/S) services and Medical Nutrition Therapy (MNT); OR</p> <p>2) Condition-specific pathways – Documented use of evidenced-based condition-specific pathways for chronic conditions (e.g., hypertension, diabetes, depression, asthma, heart failure). These might</p>	2017

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			<p>Program (DRP) and the NCQA Heart/Stroke Recognition Program (HSRP);</p> <ul style="list-style-type: none"> • Use pre-visit planning, that is, preparations for conversations or actions to propose with patient before an in-office visit to optimize preventive care and team management of patients with chronic conditions; • Use panel support tools, (that is, registry functionality) or other technology that can use clinical data to identify trends or data points in patient records to identify services due; • Use predictive analytical models to predict risk, onset and progression of chronic diseases; and/or • Use reminders and outreach (e.g., phone calls, emails, postcards, patient portals, and community health workers where available) to alert and educate patients about 		<p>include, but are not limited to, the National Committee for Quality Assurance (NCQA) Diabetes Recognition Program (DRP) and the NCQA Heart/Stroke Recognition Program (HSRP); OR</p> <p>3) Pre-visit planning – Use of pre-visit planning to optimize preventive care and team management (e.g., workflow indicating pre-visit planning process); OR</p> <p>4) Panel support tools – Use of panel support tools (e.g., registry or other technology) to identify services that are due in patient records; OR</p> <p>5) Reminders and outreach – Use of reminders and outreach (e.g., phone calls, emails, postcards, patient portals) to alert and educate patients about services due and/or routine medication reconciliation (e.g., workflow indicating reminder and outreach process, outreach language, screenshot of reminders); OR</p> <p>6) Risk prediction report – Documentation of the predictive analytical models used to predict risk, onset, and progression of chronic diseases for patient population.</p>	

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			services due; and/or routine medication reconciliation.			
IA_PM_14	Population Management	Implementation of methodologies for improvements in longitudinal care management for high risk patients	<p>Provide longitudinal care management to patients at high risk for adverse health outcome or harm that could include one or more of the following:</p> <ul style="list-style-type: none"> • Use a consistent method to assign and adjust global risk status for all empaneled patients to allow risk stratification into actionable risk cohorts. Monitor the risk-stratification method and refine as necessary to improve accuracy of risk status identification; • Use a personalized plan of care for patients at high risk for adverse health outcome or harm, integrating patient goals, values and priorities; and/or • Use on-site practice-based or shared care managers to proactively monitor and coordinate care for the highest risk cohort of patients. 	Medium	<p><u>Objective:</u> Improve health outcomes and patient-centeredness of care for patients at high-risk for adverse health outcomes or harm.</p> <p><u>Validation Documentation:</u> Evidence of longitudinal, or relationship-based, care management of patients at high-risk for adverse health outcomes as defined by the eligible clinician. Include both of the following elements:</p> <p>1) List of high-risk patients – Identification of patients at high-risk for adverse health outcome or harm; AND</p> <p>2) Use of longitudinal care management – Documented use of longitudinal care management methods including at least one of the following: a) empaneled patient risk assignment and risk stratification into actionable risk cohorts; b) personalized care plans for patients at high risk for adverse health outcome or harm; or c) evidence of use of care managers to monitor and coordinate care for highest risk cohorts.</p> <p><u>Example(s):</u> A cardiologist practice learns that a high percentage of their congestive heart failure (CHF) patients are being re-admitted to the hospital within</p>	2017

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					30 days of a previous admission for CHF. The cardiology group undertakes practice changes to minimize total CHF hospital admissions. Initially, they identify their population in a manner most appropriate to their practice. Examples might include the stage of CHF or patients with any hospital admission within a certain period of time. Then they team with their nursing staff to create a plan that includes an initial discussion with each patient and plans for monitoring weight and diet daily and on a regular basis by phone, email, or electronic medical record patient portal. Additionally, the patients in the cohort are given access to a direct nursing phone line for questions or with specific concerns such as sudden weight gain. An example of a goal would be identification of sudden weight gain with subsequent temporary increases in diuretic dosing, all completed at home.	
IA_PM_15	Population Management	Implementation of episodic care management practice improvements	Provide episodic care management, including management across transitions and referrals that could include one or more of the following: <ul style="list-style-type: none"> • Routine and timely follow-up to hospitalizations, ED visits and stays in other institutional settings, including symptom and disease 	Medium	<p><u>Objective:</u> Use episodic care management to improve quality of care and communication across referrals and transitions of care.</p> <p><u>Validation Documentation:</u> Evidence of episodic care management practice improvements. Include at least one of the following elements:</p> <p>1) Follow-up on hospitalizations, emergency department (ED), or other visits, and medication</p>	2017

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
			<p>management, and medication reconciliation and management; and/or</p> <ul style="list-style-type: none"> Managing care intensively through new diagnoses, injuries and exacerbations of illness. 		<p>management – Routine and timely follow-up to hospitalizations, ED, or other institutional visits, and medication reconciliation and management (e.g., documented in medical record or electronic health record [EHR]); OR</p> <p>2) New diagnoses, injuries and exacerbations – Intensive care management at time of new diagnoses, injuries, and exacerbations of illness documented in medical record or EHR.</p> <p><u>Example(s)</u>: An oncology practice chooses to implement processes to streamline the initial evaluation and care planning of cancer patients. The practice noted previous inefficiencies as related to biomarker testing and therefore, as part of the process development, they identified attributes to biomarker testing that will be beneficial to efficiency improvements:</p> <ul style="list-style-type: none"> Implement and document frequent multidisciplinary meetings that engage medical oncologists early in biomarker testing workflow. Set up direct lines of communication between payers and practices to prevent unnecessary back-and-forth clarifications. Codify prior authorization requirements for the most common payer organizations to streamline coverage 	

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
					<p>decisions.</p> <ul style="list-style-type: none"> • Institute standard reflexive policies of most common tests for first line treatment decisions triggered by diagnosis. • Implement modern electronic forms for test ordering and communication platforms between medical oncologists and pathology. • Enact and document specimen logistics best practices that streamline shipping to external labs. 	
IA_PM_16	Population Management	Implementation of medication management practice improvements	<p>Manage medications to maximize efficiency, effectiveness and safety that could include one or more of the following:</p> <ul style="list-style-type: none"> • Reconcile and coordinate medications and provide medication management across transitions of care settings and eligible clinicians or groups; • Integrate a pharmacist into the care team; and/or • Conduct periodic, structured medication reviews. 	Medium	<p><u>Objective:</u> Maximize the efficiency, effectiveness, and safety of care across settings by strengthening medication management.</p> <p><u>Validation Documentation:</u> Evidence of newly implemented medication management practice improvements. Eligible clinicians should include all prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements a patient is currently taking within the purview of the medication management process. Include at least one of the following elements:</p> <p>1) Documented medication reconciliation – Patient medical records demonstrating periodic structured medication reviews or reconciliation, which includes updating, reviewing, or obtaining each medication's name, dosage, frequency, and administered route; OR</p>	2017

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
					<p>2) Integrated pharmacist – Evidence of pharmacist integrated into care team; OR</p> <p>3) Reconciliation across transitions – Patient medical record demonstrating medication reconciliation at the time of the transition. For example, when a patient is being discharged from hospital to home, the reconciliation would be completed at discharge from a hospital by the discharging eligible clinician and at follow-up by the outpatient and/or primary eligible clinician; OR</p> <p>4) Medication management improvement plan – Report detailing medication management practice improvement plan, and outcomes, if available. For example, the "Agency for Healthcare Research and Quality (AHRQ) Create a Safe Medicine List Together" strategy could be implemented.</p>	
IA_PM_17	Population Management	Participation in Population Health Research	Participation in federally and/or privately funded research that identifies interventions, tools, or processes that can improve a targeted patient population.	Medium	<p><u>Objective:</u> Contribute to the development of evidence-based interventions, tools, or processes for improving health outcomes.</p> <p><u>Validation Documentation:</u> Evidence supporting participation in a federally and/or privately funded research initiative to identify systems, tools, or strategies that improve patient outcomes for a targeted population. Include both of the following elements:</p>	2018

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
					<p>1) Confirmed participation – Documentation of participation in a federally and/or privately funded research initiative; AND</p> <p>2) Research intervention details – List of the interventions, tools, or processes used in the research including identified population(s) and health outcomes targeted.</p>	
IA_PM_18	Population Management	Provide Clinical-Community Linkages	Engaging community health workers to provide a comprehensive link to community resources through family-based services focusing on success in health, education, and self-sufficiency. This activity supports individual MIPS eligible clinicians or groups that coordinate with primary care and other clinicians, engage and support patients, use of health information technology, and employ quality measurement and improvement processes. An example of this community based program is the NCQA Patient-Centered Connected Care (PCCC) Recognition Program or other such programs that meet these criteria.	Medium	<p><u>Objective:</u> Help patients and families access the right community resources for improving/maintaining health, education, and self-sufficiency with support from community health workers.</p> <p><u>Validation Documentation:</u> Evidence of engagement with community health workers to provide a comprehensive link to community resources and family-based services with an emphasis on improving health, education, and self-sufficiency. Include all of the following elements:</p> <p>1) Community health worker engagement – Documentation of active engagement with community health workers to collaborate in helping patients served by the practice address risk factors related to social determinants of health (e.g., electronic health records referencing community health worker engagement, paperwork related to engagement of community health workers); AND</p>	2018

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
					<p>2) Coordination and patient engagement – Documentation of coordination with primary care and other eligible clinicians to engage and support patients (e.g., use of health information technology); AND</p> <p>3) Measure and monitoring – Evidence of use of quality measurement and improvement processes (e.g., National Committee for Quality Assurance’s Patient-Centered Connected Care [PCCC] Recognition Program or similar programs) to continuously improve engagement and coordination with community health workers and other clinicians in an effort to improve patient wellbeing and health (e.g., dashboards, reports).</p> <p><u>Example(s)</u>: A primary healthcare practice may work with community health workers to help patients with limited English language skills understand and adhere to new plans for diet and medication, learn how to use and manage medical equipment, and provide information on local support groups for people with diabetes. The community health workers report back to the eligible clinicians at the primary healthcare practice; the eligible clinicians then communicate as relevant to other eligible clinicians providing care to the patients and monitor to improve community health worker engagement and the outcomes of the</p>	

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
					<p>patients they see.</p> <p><u>Information:</u></p> <ul style="list-style-type: none"> Centers for Disease Control and Prevention's (CDC's) Community Health Workers Toolkit: https://www.cdc.gov/dhds/pubs/toolkits/chw-toolkit.htm Association of State and Territorial Health Officials Clinical to Community Connections: https://www.astho.org/Community-Health-Workers/ 	
IA_PM_19	Population Management	Glycemic Screening Services	For at-risk outpatient Medicare beneficiaries, individual MIPS eligible clinicians and groups must attest to implementation of systematic preventive approaches in clinical practice for at least 60 percent for the 2018 performance period and 75 percent in future years, of electronic medical records with documentation of screening patients for abnormal blood glucose according to current US Preventive Services Task Force (USPSTF) and/or American Diabetes Association (ADA) guidelines.	Medium	<p><u>Objective:</u> Screen more patients at risk for diabetes.</p> <p><u>Validation Documentation:</u> Evidence demonstrating the implementation of an abnormal blood glucose screening program focused on at-risk populations. The population/s for this activity are to be defined by the eligible clinician and might include (but are not limited to): patients over a certain Body Mass Index, patients with a family history of diabetes, or patients of an at-risk race or ethnicity. Include both of the following elements:</p> <ol style="list-style-type: none"> At-risk population identified – Total stratified number of Medicare patients at risk for abnormal blood glucose; AND Percent of population screened – Total number and percentage of at-risk population screened for 	2018

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
					abnormal blood glucose as outlined by the US Preventive Services Task Force and/or American Diabetes Association guidelines.	
IA_PM_20	Population Management	Glycemic Referring Services	For at-risk outpatient Medicare beneficiaries, individual MIPS eligible clinicians and groups must attest to implementation of systematic preventive approaches in clinical practice for at least 60 percent for the CY 2018 performance period and 75 percent in future years, of medical records with documentation of referring eligible patients with prediabetes to a CDC-recognized diabetes prevention program operating under the framework of the National Diabetes Prevention Program.	Medium	<p><u>Objective:</u> Refer more patients with pre-diabetes to a recognized preventive program to help prevent or slow disease progression.</p> <p><u>Validation Documentation:</u> Evidence demonstrating the implementation of a comprehensive approach for screening for prediabetes. Include both of the following elements:</p> <p>1) Identified Medicare patients at-risk – Total stratified number of Medicare patients at risk for abnormal blood glucose as outlined by the US Preventive Services Task Force (USPSTF) and/or American Diabetes Association (ADA) guidelines; AND</p> <p>2) Percentage of patients receiving diabetes prevention program referral – Total number and percentage of the at-risk population receiving referral to a Centers for Disease Control and Prevention recognized diabetes prevention program operating under the framework of the National Diabetes Prevention Program.</p>	2018
IA_PM_21	Population Management	Advance Care Planning	Implementation of practices/processes to develop advance care planning that	Medium	<u>Objective:</u> Increase the frequency and quality of advanced care planning and documentation.	2018

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
			includes: documenting the advance care plan or living will within the medical record, educating clinicians about advance care planning motivating them to address advance care planning needs of their patients, and how these needs can translate into quality improvement, educating clinicians on approaches and barriers to talking to patients about end-of-life and palliative care needs and ways to manage its documentation, as well as informing clinicians of the healthcare policy side of advance care planning.		<p><u>Validation Documentation:</u> Evidence supporting implementation of practices/processes to improve advance care planning. Include all of the following elements:</p> <p>1) Documentation approach – Standardized approach to documenting advance care plan or living will within the medical record (e.g., a medical record template or other defined, standardized method to include specific attributes defined by the eligible clinician) and storage of any relevant copies of patient documents when appropriate; AND</p> <p>2) Patient identification – Identification of the population of patients, as defined by the eligible clinician (e.g., all patients over 65, patients with specific diagnoses, all patients) who would be subject to the eligible clinician’s practices/processes for encouraging advance care planning; AND</p> <p>3) Eligible clinician education on advance care planning – Documentation of eligible clinician education (e.g., training curriculum or agenda, training materials) on approaches to advance care planning at the level of the individual patient.</p>	
IA_CC_1	Care Coordination	Implementation of use of specialist reports back to	Performance of regular practices that include providing specialist reports back to the referring individual MIPS eligible clinician or	Medium	<p><u>Objective:</u> Improve clinician-to-clinician communication to prevent delayed and/or inappropriate treatment while increasing patient satisfaction and adherence to treatment.</p>	2017

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
		referring clinician or group to close referral loop	group to close the referral loop or where the referring individual MIPS eligible clinician or group initiates regular inquiries to specialist for specialist reports which could be documented or noted in the EHR technology.		<p><u>Validation Documentation:</u> Evidence that relevant records from patient/consultant (internal or external specialist) interactions are sent to the referring eligible clinician. Include one of the following elements:</p> <p>1) Report – Evidence that the consultant always sends a report to the referring eligible clinician; OR</p> <p>2) Process for capturing referral information – Evidence that the referring eligible clinician has a defined method for capturing reports in the medical record (e.g., a) reports transmitted between electronic health records [EHRs]; b) documents that are electronically scanned and linked to the patient's EHR; or c) chart documentation of the relevant details of the consultant patient interaction such as notes written into a progress note).</p>	
IA_CC_2	Care Coordination	Implementation of improvements that contribute to more timely communication of test results	Timely communication of test results defined as timely identification of abnormal test results with timely follow-up.	Medium	<p><u>Objective:</u> Reduce risk of patient harm that occurs when abnormal test results are not delivered in a timely way.</p> <p><u>Validation Documentation:</u> Evidence of a process that reduces the time needed before communicating test results to the patient. The eligible clinician may define the population of patients within their practice for the improvement based on specific test ordered, patient diagnosis, or another factor. Include all of the</p>	2017

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
					<p>following elements:</p> <p>1) Population identified – Characteristics of the population targeted and methods for capturing the entire population within your practice; AND</p> <p>2) Documentation of method/s of communication and benchmark for timeliness of communication – The benchmark for timeliness of communication can be determined and measured in a variety of ways and should be defined by the eligible clinician in a way that will best meet the goals of the activity (e.g., actual times from an electronic health record or improvements in customer service reviews); AND</p> <p>3) Improvement strategies – The strategies used to improve timeliness are defined and must be documented by the eligible clinician.</p> <p><u>Example(s):</u></p> <ul style="list-style-type: none"> • An internal medicine eligible clinician chooses to follow their population of diabetic patients with a focus on the HbA1c blood test. Traditionally, they do not communicate those test results outside of patient visits. The plan to meet the activity is to communicate normal results with a congratulatory note by email or mail and to communicate abnormal results by phone to ensure the patient understands the need for management of blood sugar more effectively. In this 	

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
					<p>case, the eligible clinician improved the timely communication to meet the activity and also added context relevant to the patient population.</p> <ul style="list-style-type: none"> • A radiology group that has a busy mammography practice routinely communicates normal mammogram results within 1-2 weeks and abnormal results are followed up with a phone call by a nurse. The radiology group decides to focus on all patients with a prior diagnosis of breast cancer. They develop a process to capture 100% of patients with prior history at the time of their mammogram and they provide real-time results to those patients by the radiologist. They improve the time to results on the identified population and significantly reduce the anxiety of waiting for a group of patients who are most prone to anxiety. 	
IA_CC_7	Care Coordination	Regular training in care coordination	Implementation of regular care coordination training.	Medium	<p><u>Objective:</u> Utilize preferred practice patterns within your practice to improve care coordination.</p> <p><u>Validation Documentation:</u> Evidence of participation in/implementation of regular care coordination training within the attestation period. Include the following element:</p> <p>1) Care coordination training – Examples include availability of care coordination training</p>	2017

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
					curriculum/training materials and attendance or training certification registers/documents.	
IA_CC_8	Care Coordination	Implementation of documentation improvements for practice/process improvements	Implementation of practices/processes that document care coordination activities (e.g., a documented care coordination encounter that tracks all clinical staff involved and communications from date patient is scheduled for outpatient procedure through day of procedure).	Medium	<p><u>Objective:</u> Develop and utilize processes that improve care coordination outcomes.</p> <p><u>Validation Documentation:</u> The eligible clinician identifies an area within their practice in which improved care coordination will improve an outcome. The area(s) for improvement, intervention strategies, and the outcome goals are to be defined by the eligible clinicians involved. Evidence of newly implemented processes and practices to improve care coordination, including both of the following elements:</p> <p>1) Care coordination process documentation – Documentation of the implementation of practices/processes that document care coordination activities (e.g., record of meeting minutes to discuss changes, swim lane workflow diagram, agenda noting training on new practices/processes for staff, copy of old and new practices/processes on documenting care coordination activities); AND</p> <p>2) Care coordination outcomes – Documentation of, or ability to demonstrate evidence of, the outcomes from newly implemented practices/processes.</p>	2017

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
					<u>Example(s)</u> : An eligible family practice (FP) clinician frequently sees patients in follow-up after emergency department (ED) visits. The eligible clinician does not have immediate access to the ED records and the process of requesting the records is cumbersome and not practical at the time of follow-up. The eligible clinician works with the ED to create an automatic process within the electronic health record so that a brief summary of the ED visit is forwarded to the eligible clinician doing the follow-up. This would require that the eligible ED clinicians always document a brief summary even when they have not completed the full record and it would require information technology support to generate the email/fax, etc. All eligible clinicians involved (FP and ED) get credit for this activity.	
IA_CC_9	Care Coordination	Implementation of practices/processes for developing regular individual care plans	Implementation of practices/processes, including a discussion on care, to develop regularly updated individual care plans for at-risk patients that are shared with the beneficiary or caregiver(s). Individual care plans should include consideration of a patient's goals and priorities, as well as desired outcomes of care.	Medium	<p><u>Objective</u>: Develop, maintain, and share personalized care plans with at-risk patients to promote patient-centered care and improve patient experience.</p> <p><u>Validation Documentation</u>: Evidence of processes for developing and updating individual care plans for at-risk patients and sharing them with beneficiary and/or caregiver. Areas of focus and consideration might include social determinants of health, language and communication preferences, physical or cognitive</p>	2017

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
					<p>limitations, as well as desired outcomes of care. Include both of the following elements:</p> <p>1) Individual care plans for at-risk patients – Documentation of process for developing individual care plans for clinician-defined at-risk patients (e.g., template care plan, standardized type of note in the health record); AND</p> <p>2) Use of care plan with beneficiary – Patient medical records demonstrating the documentation of the care plan using a standardized approach.</p> <p><u>Example(s)</u>: An eligible internal medicine clinician has a population within the practice of frail elderly patients who periodically miss appointments and have not refilled prescriptions. Many are at risk of falls. A plan is developed to identify all of these patients and create a template portion of the electronic health record that asks specific questions regarding caregiver support, ability to travel to appointments and the pharmacy, and the ability to get help whenever needed. The eligible clinician and staff work to help the patient identify solutions to problems.</p>	
IA_CC_10	Care Coordination	Care transition documentation practice improvements	In order to receive credit for this activity, a MIPS eligible clinician must document practices/processes for care	Medium	<p><u>Objective</u>: Define and implement a standardized process for transitions of care that are relevant to the eligible clinician's patient population.</p>	2017

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
			transition with documentation of how a MIPS eligible clinician or group carried out an action plan for the patient with the patient's preferences in mind (that is, a "patient-centered" plan) during the first 30 days following a discharge. Examples of these practices/processes for care transition include: staff involved in the care transition; phone calls conducted in support of transition; accompaniments of patients to appointments or other navigation actions; home visits; patient information access to their medical records; real time communication between PCP and consulting clinicians; PCP included on specialist follow-up or transition communications.		<p><u>Validation Documentation:</u> Evidence of processes for preparing and implementing patient-centered care transition plans for the first 30 days following a discharge. Include at least two of the following elements:</p> <p>1) Patient-centered care transition action plans – Documented plans to include out-patient follow-up, medication reconciliation, and post-discharge support. May include: a) patient communications and language preferences; b) available supports and services (medication availability and travel capability); c) patient's discharge environment, or d) out-patient follow-up plan; OR</p> <p>2) Implementation of action plan within first 30 days of discharge – May include: a) documentation of staff involved in the care transition; b) records of real-time communication between eligible primary care clinicians and consulting eligible clinicians; or c) records of eligible primary care clinicians included on specialist follow-up transition communication, etc.; OR</p> <p>3) Patient communication and delivery of support services according to patient preferences within first 30 days of discharge – Examples from patient records that demonstrate conformity with patient preferences. May include: a) patient-preferred communication activities such as phone calls</p>	

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
					<p>conducted in support of transition; b) accompaniments of patient to appointments or other navigation actions; c) home visits; patients' access to their medical records; or d) translated discharge materials, etc.; OR</p> <p>4) Processes for care transition planning – Documentation that defines the steps the eligible clinician will take to prepare and implement the patient-centered care transition plan with every patient.</p> <p><u>Information:</u> Guide to reducing disparities in readmissions: https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/OMH_Readmissions_Guide.pdf</p>	
IA_CC_11	Care Coordination	Care transition standard operational improvements	<p>Establish standard operations to manage transitions of care that could include one or more of the following:</p> <ul style="list-style-type: none"> • Establish formalized lines of communication with local settings in which empaneled patients receive care to ensure documented flow of information and seamless transitions in care; and/or 	Medium	<p><u>Objective:</u> Enhance communication during care transitions to improve patient outcomes by establishing standard operations, or preferred practice patterns, for transition communications.</p> <p><u>Validation Documentation:</u> Evidence of information flow during transitions of care. Include at least one of the following elements:</p> <p>1) Communication lines with local settings – Documentation of standardized lines of</p>	2017

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
			<ul style="list-style-type: none"> • Partner with community or hospital-based transitional care services. 		<p>communication to manage transitions of care between settings. Communication can occur in whatever format is most useful based on the circumstances of the eligible clinicians; OR</p> <p>2) Partnership with community or hospital-based transitional care services – Documentation showing partnership with community or hospital-based transitional care services (e.g., written agreement, workflow documentation).</p> <p><u>Example(s):</u></p> <ul style="list-style-type: none"> • A busy hospitalist group in a community hospital has heard complaints from eligible out-patient care primary care clinicians, who report that they are following up on discharged patients without understanding the details of the admission or the changes in medications made. To address this complaint, the hospitalist group creates an electronic health record-based system by which a discharge summary is completed within 24 hours of discharge and which is automatically sent to the patient's eligible primary care clinician (email, fax, etc.). The summary includes medication reconciliation information. • Emergency departments see many patients with chest pain daily. An emergency department (ED) eligible clinician group meets with the cardiology 	

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
					eligible clinician group to arrange for immediate follow-up on moderate-risk chest pain patients after patients have been cleared for discharge by the ED. A telephone conversation occurs between the eligible ED clinician and the eligible cardiologist for every discharged patient who will be seen within 24 hours for evaluation and exercise stress test.	
IA_CC_12	Care Coordination	Care coordination agreements that promote improvements in patient tracking across settings	<p>Establish effective care coordination and active referral management that could include one or more of the following:</p> <ul style="list-style-type: none"> • Establish care coordination agreements with frequently used consultants that set expectations for documented flow of information and MIPS eligible clinician or MIPS eligible clinician group expectations between settings. Provide patients with information that sets their expectations consistently with the care coordination agreements; • Track patients referred to specialist through the entire process; and/or • Systematically integrate 	Medium	<p><u>Objective:</u> Improve processes for care coordination and active referral management, thus making care more effective and efficient, preventing risky delays and under-treatment, and increasing patient satisfaction and adherence to treatment.</p> <p><u>Validation Documentation:</u> Evidence of care coordination and referral management. Include at least one of the following elements:</p> <p>1) Care coordination agreements – Documentation of care coordination agreements that establish flow of information and provide patients with information to set consistent expectations; OR</p> <p>2) Tracking of patient referrals to specialists – Medical record or electronic health record documentation demonstrating tracking of patients referred to specialists through the entire process; OR</p> <p>3) Referral information integrated into the plan of</p>	2017

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
			information from referrals into the plan of care.		care – Samples of specialist referral information systematically integrated into the plan of care.	
IA_CC_13	Care Coordination	Practice improvements to align with OpenNotes principles	Adherence to the principles described in the OpenNotes initiative (https://www.opennotes.org) to ensure that patients have full access to their patient information to guide patient care.	Medium	<p><u>Objective:</u> Utilize a program or process that provides an open exchange of necessary patient information between care teams and patients to guide patient care.</p> <p><u>Validation Documentation:</u> Evidence of full access to patient information (between care team and patient) to guide patient care. Required clinical documentation from a medical record available in a patient portal using United States Core Data for Interoperability (USCDI) standards, including consultation, as relevant to each patient. Medical records that are not required to be available include psychotherapy notes that are separated from the rest of the individual's medical record and information compiled in reasonable anticipation of, or use in a civil, criminal, or administrative action or proceeding.</p> <p><u>Information:</u> The federal rule on 'Interoperability and Information Blocking' mandates that U.S. healthcare providers give patients access to all the health information in their electronic medical records "without delay" and without charge. Information on the Cures Act Final Rule and Information Blocking</p>	2017

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
					'Actors' can be found here: https://www.healthit.gov/topic/information-blocking ; information on the OpenNotes initiative can be found here: https://www.opennotes.org	
IA_CC_15	Care Coordination	PSH Care Coordination	Participation in a Perioperative Surgical Home (PSH) that provides a patient-centered, physician-led, interdisciplinary, and team-based system of coordinated patient care, which coordinates care from pre-procedure assessment through the acute care episode, recovery, and post-acute care. This activity allows for reporting of strategies and processes related to care coordination of patients receiving surgical or procedural care within a PSH. The clinician must perform one or more of the following care coordination activities: <ul style="list-style-type: none"> • Coordinate with care managers/navigators in preoperative clinic to plan and implementation comprehensive post discharge plan of care; • Deploy perioperative clinic and 	High	<p><u>Objective:</u> Participate in a Perioperative Surgical Home (PSH) model to improve coordination of patient care through the acute-care episode, recovery, and post-acute care.</p> <p><u>Validation Documentation:</u> Evidence of participation in a PSH model that provides a patient-centered, clinician-led, interdisciplinary, and team-based system of coordinated patient care. Include at least one of the following elements:</p> <p>1) Coordination with care managers/navigators in preoperative clinic – Documented conversations with care managers/navigators (e.g., electronic health record note) to plan and implement comprehensive post-discharge plan of care that could take into account patients' post-discharge environment and support system out of the hospital; OR</p> <p>2) Perioperative care process improvements – Documentation of evidence-informed perioperative clinic and care processes implemented to standardize care across the spectrum of surgical patients (e.g., workflow diagrams, word document of written policies</p>	2018

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
			care processes to reduce post-operative visits to emergency rooms; <ul style="list-style-type: none"> • Implement evidence-informed practices and standardize care across the entire spectrum of surgical patients; or • Implement processes to ensure effective communications and education of patients' post-discharge instructions. 		and procedures); OR 3) Patient education and improvement – Implement processes to ensure effective communication of and education on patients' discharge instructions, taking into account patients' literacy level, language and communication preferences, and cognitive or functional impairments.	
IA_CC_16	Care Coordination	Primary Care Physician and Behavioral Health Bilateral Electronic Exchange of Information for Shared Patients	The primary care and behavioral health practices use the same electronic health record system for shared patients or have an established bidirectional flow of primary care and behavioral health records.	Medium	<p><u>Objective:</u> Improve whole-person care by establishing bidirectional communication between eligible primary care clinicians and behavioral health practices for shared patients.</p> <p><u>Validation Documentation:</u> Evidence of collaboration and bidirectional flow of patient information between eligible primary care clinician(s) and behavioral health practice/s where electronic health records (EHRs) share common patients. Include the following element:</p> <p>1) Communication exchange – Documentation of established bidirectional communication and information-sharing between primary care and behavioral health practices that share common</p>	2018

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
					<p>patients or use the same EHR systems.</p> <p><u>Example(s)</u>: A small primary care practice of eligible clinicians finds that they often are not aware of the mental health issues their patients are being treated for, and in particular, are often unaware of additions or changes in psychiatric medications. The group does not have the ability to connect their electronic medical record with that of the mental healthcare clinicians and there is no health information exchange available. To solve their problem, they identified all patients with psychiatric medications prescribed outside their practice and all patients known to be receiving mental health treatment. With the patient's permission, the notes from the mental health visits and associated medication information are faxed or emailed and medication reconciliation occurs with all medication changes.</p>	
IA_CC_17	Care Coordination	Patient Navigator Program	Implement a Patient Navigator Program that offers evidence-based resources and tools to reduce avoidable hospital readmissions, utilizing a patient-centered and team-based approach, leveraging evidence-based best practices to improve	High	<p><u>Objective</u>: Reduce avoidable hospital readmissions and make hospital stays less stressful and recovery periods more supportive for patients.</p> <p><u>Validation Documentation</u>: Evidence of participation in a Patient Navigator Program (PNP) designed to meet this activity's objective. Include all of the following elements:</p>	2018

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
			care for patients by making hospitalizations less stressful, and the recovery period more supportive by implementing quality improvement strategies.		<p>1) PNP participation – Confirmation of participation in PNP. PNP should take into account patients' language and communication preferences, literacy level, and cognitive and physical disabilities; AND</p> <p>2) Documentation of tools to reduce avoidable hospital readmissions – Tools should be evidence-based whenever possible; AND</p> <p>3) Quality improvement strategies – Implementation of systems, tools, and strategies as part of the PNP that aim to achieve the objective of this activity. May include workflows and approaches that assist patients with communicating with eligible healthcare clinicians regarding their questions, obtaining information about their procedures/treatments, and arranging for test or appointments.</p>	
IA_CC_18	Care Coordination	Relationship-Centered Communication	In order to receive credit for this activity, MIPS eligible clinicians must participate in a minimum of eight hours of training on relationship-centered care tenets such as making effective open-ended inquiries; eliciting patient stories and perspectives; listening and responding with empathy; using the ART (ask, respond, tell) communication technique to	Medium	<p><u>Objective:</u> Improve quality of patient-clinician communication and interaction by attending training on relationship-centered care and communication techniques.</p> <p><u>Validation Documentation:</u> Evidence that the eligible clinician spent a minimum of eight hours of training focused on relationship-centered care. Include both of the following elements:</p> <p>1) Certificate of completion – Documentation of completing 8 hours of training with patient-centered</p>	2019

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			engage patients, and developing a shared care plan. The training may be conducted in formats such as, but not limited to: interactive simulations practicing the skills above, or didactic instructions on how to implement improvement action plans, monitor progress, and promote stability around improved clinician communication.		care training title, eligible clinician's name, and date of completion (e.g., certificate of completion, screenshot of module completion). The training may be conducted in formats such as, but not limited to: interactive simulations practicing the skills listed in the activity description, or didactic instructions on how to a) implement improvement action plans; b) monitor progress; and c) promote stability around improved clinician communication; AND 2) Details on patient-centered care training – Provide details on patient-centered care training components. Training should include such topics as: a) making effective open-ended inquiries; b) eliciting patient stories and perspectives; c) listening and responding with empathy; d) using a specific technique such as ART (ask, respond, tell) to engage patients; or e) developing a shared care plan.	
IA_CC_19	Care Coordination	Tracking of clinician's relationship to and responsibility for a patient by reporting MACRA patient	To receive credit for this improvement activity, a MIPS eligible clinician must attest that they reported MACRA patient relationship codes (PRC) using the applicable HCPCS modifiers on 50 percent or more of their Medicare claims for a minimum of a continuous 90-day period within	High	<u>Objective:</u> Increase the utilization of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) patient relationship codes (PRC) using the applicable Healthcare Common Procedure Coding System (HCPCS) modifiers on Medicare claims. Using PRC ensure that appropriate attribution is assigned to the appropriate eligible clinician. For example, it would be inappropriate to attribute the cost of an aortic aneurysm repair to the ophthalmologist who	2020

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		relationship codes	the performance period. Reporting the PRC modifiers enables the identification of a clinician's relationship with, and responsibility for, a patient at the time of furnishing an item or service. See the CY 2018 PFS final rule (82 FR 53232 through 53234) for more details on these codes.		<p>performed a cataract surgery in the same calendar year.</p> <p><u>Validation Documentation:</u> Documentation that MIPS eligible clinician(s) reported MACRA PRC using the applicable HCPCS modifiers on 50% or more of their Medicare claims MACRA patient relationship codes articulate the relationship and responsibility of an eligible clinician with a patient at the time of furnishing an item or service, thereby facilitating the attribution of patients and episodes to one or more eligible clinicians for purposes of cost measurement. Include the following element:</p> <p>1) MACRA PRC HCPCS modifiers on 50% of Medicare claims – Documentation could be captured in the patient chart or electronic health record; note that the eligible clinician reported MACRA PRC using the applicable HCPCS modifiers on 50% or more of their Medicare claims for a continuous 90-day minimum reporting period within the performance year.</p>	
IA_BE_1	Beneficiary Engagement	Use of certified EHR to capture patient reported outcomes	To improve patient access, perform activities beyond routine care that enable capture of patient reported outcomes (for example, related to functional status, symptoms and symptom burden, health behaviors,	Medium	<p><u>Objective:</u> Improve patient engagement through patient/clinician review of patient collected information or through assessment of a patient's understanding, confidence, and ability to perform self-care.</p>	2017

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			or patient experience) or patient activation measures (that is, measures of patient involvement in their care) through use of certified electronic health record technology, and record these outcomes data for clinician review.		<p><u>Validation Documentation:</u> Evidence of patient reported data and/or outcomes in the certified electronic health record technology (CEHRT). Include the following element:</p> <p>1) Patient reported outcomes/self-management – Documentation demonstrating use of one or more measures that assess patients' involvement in their care or their understanding, confidence, and ability to care for oneself. The eligible clinician should incorporate the results of the assessment into the patient's overall plan of care, as deemed most appropriate for their population. As necessary or helpful, also include patient's data in the CEHRT.</p> <p><u>Example(s)/Information:</u></p> <ul style="list-style-type: none"> • Examples of online questionnaires for collecting patient-reported data: <ul style="list-style-type: none"> o Quick and full online health check-up: www.HealthConfidence.org o www.MedicareHealthAssess.org • Inventory of patient-reported outcome measures: www.healthmeasures.net/explore-measurement-systems/promis • The Patient Activation Measure: https://cmit.cms.gov/CMIT_public/ViewMeasure?MeasureId=327 	

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
IA_BE_3	Beneficiary Engagement	Engagement with QIN-QIO to implement self-management training programs	Engagement with a Quality Innovation Network-Quality Improvement Organization, which may include participation in self-management training programs such as diabetes.	Medium	<p><u>Objective:</u> Become more equipped to help patients self-manage their chronic conditions.</p> <p><u>Validation Documentation:</u> Evidence of Quality Innovation Network-Quality Improvement Organization (QIN-QIO) relationship to implement self-management training programs. Include the following element:</p> <p>1) QIN-QIO engagement – Documentation from QIN-QIO of eligible clinician or group's engagement and use of services (e.g., email exchange, participation letter, listed on QIN-QIO website as partner) to assist with participation in self-management training program(s) such as the Diabetes Self-Management Program (DSMP).</p>	2017
IA_BE_4	Beneficiary Engagement	Engagement of patients through implementation of improvements in patient portal	To receive credit for this activity, MIPS eligible clinicians must provide access to an enhanced patient/caregiver portal that allows users (patients or caregivers and their clinicians) to engage in bidirectional information exchange. The primary use of this portal should be clinical and not administrative. Examples of the use of such a portal include, but are not	Medium	<p><u>Objective:</u> Increase patient engagement, adherence to treatment plans, and self-management of chronic conditions through the availability of a patient portal within the electronic health record (EHR).</p> <p><u>Validation Documentation:</u> Evidence of a functioning patient portal that includes patient interactive features or up-to-date information on disease or symptom management. Include at least one of the following elements:</p> <p>1) Enhanced patient portal screenshots –</p>	2017

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			limited to: brief patient reevaluation by messaging; communication about test results and follow up; communication about medication adherence, side effects, and refills; blood pressure management for a patient with hypertension; blood sugar management for a patient with diabetes; or any relevant acute or chronic disease management.		<p>Documentation through screenshots of an enhanced patient portal that displays at least one of the following functions or features: a) bidirectional communication between patient and eligible clinician or care team (e.g., messaging for questions, medication refills, appointment scheduling); or b) availability of health information and education regarding the patient's conditions; OR</p> <p>2) Patient portal use reports – Reports of patient portal engagement detailing patient use of interactive functions (e.g., bidirectional communication between patient and eligible clinician or care team about medication changes and adherence).</p> <p><u>Information:</u> If an eligible clinician is using Open Notes (https://protect2.fireeye.com/url?k=193efc00-456bf5d0-193ecd3f-0cc47a6a52de-68b30e439d31f40b&u=https://www.opennotes.org/) for bidirectional patient-clinician communication, they may find IA_CC_13, "Practice Improvements for Bilateral Exchange of Patient Information", an applicable activity to attest to.</p>	
IA_BE_5	Beneficiary Engagement	Enhancements/regular updates to practice websites/tools	Enhancements and ongoing regular updates and use of websites/tools that include consideration for compliance with section 508 of the	Medium	<p><u>Objective:</u> Ensure eligible clinicians' website content and tools more accessible to people with disabilities.</p> <p><u>Validation Documentation:</u> Evidence that updated</p>	2017

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		that also include considerations for patients with cognitive disabilities	Rehabilitation Act of 1973 or for improved design for patients with cognitive disabilities. Refer to the CMS website on Section 508 of the Rehabilitation Act https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/Section508/index.html?redirect=/InfoTechGenInfo/07_Section508.asp that requires that institutions receiving federal funds solicit, procure, maintain and use all electronic and information technology (EIT) so that equal or alternate/comparable access is given to members of the public with and without disabilities. For example, this includes designing a patient portal or website that is compliant with section 508 of the Rehabilitation Act of 1973.		practice website/tools are compliant with Section 508 and thus provide improved access for patients with disabilities. Include both of the following elements: 1) Regular updates and Section 508 compliance process – Documentation of a process for regular updates and ensuring Section 508 compliance for the eligible clinician's patient portal or website; AND 2) Compliant website/tools – Screenshots or hard copies of the practice's website/tools demonstrating key aspects of Section 508 compliance. <u>Information:</u> Find 508 compliance information at https://www.section508.gov/ .	
IA_BE_6	Beneficiary Engagement	Regularly Assess Patient Experience of	Collect and follow up on patient experience and satisfaction data. This activity also requires follow-up on findings of assessments,	High	<u>Objective:</u> Improve patients' experience of and satisfaction with care by gathering and applying learnings from relevant data to make care more patient-centered.	2017

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		Care and Follow Up on Findings	including the development and implementation of improvement plans. To fulfill the requirements of this activity, MIPS eligible clinicians can use surveys (e.g., Consumer Assessment of Healthcare Providers and Systems Survey), advisory councils, or other mechanisms. MIPS eligible clinicians may consider implementing patient surveys in multiple languages, based on the needs of their patient population.		<p><u>Validation Documentation:</u> Evidence that patient experience and satisfaction data are collected, and that follow-up occurs through an improvement plan. Include at least two of the following elements:</p> <p>1) Report of patient experience and satisfaction – Report including collected data on patient experience and satisfaction (e.g., survey results). Report may include description of effort to implement patient surveys in multiple languages based on the needs of the patient population. The eligible clinician or practice may use a third-party administrator; AND/OR</p> <p>2) Follow-up on patient experience and satisfaction – Documentation that the eligible clinician’s practice has implemented changes based on the results of the patient experience and satisfaction data gathered and analyzed (e.g., specific improvements made to practices/processes in response to survey results); AND/OR</p> <p>3) Patient experience and satisfaction improvement plan – Documentation of a patient experience and satisfaction improvement plan.</p> <p><u>Example(s):</u> A practice offers patients the option to fill out a questionnaire after their visit. A) The practice finds that a consistent complaint is the long wait times</p>	

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					<p>and that the practice is losing patients as a result. The practice develops a plan to address wait times. B) The practice finds that there are multiple complaints about a single eligible clinician that include poor listening skills and a tendency to rush in and out of the room so fast that questions are not answered. The practice creates an education plan for the eligible clinician and also identifies and addresses environmental issues, or provides support to address personal issues, that lead the eligible clinician to feel pressure to rush through patient visits.</p> <p><u>Information:</u></p> <ul style="list-style-type: none"> • Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey for Healthcare Research and Quality: https://www.ahrq.gov/cahps/surveys-guidance/cg/index.htmlcy and https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS/MIPS • Tools and advisory councils: https://www.ahrq.gov/topics/patient-and-family-engagement.html • Patient experience surveys: https://www.ahrq.gov/cahps/surveys-guidance/index.html • Other available surveys: 	

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					https://www.rand.org/health-care/surveys_tools/psq.html	
IA_BE_12	Beneficiary Engagement	Use evidence-based decision aids to support shared decision-making	Use evidence-based decision aids to support shared decision-making.	Medium	<p><u>Objective:</u> Increase use of evidence-based decision aids to encourage shared decision-making with beneficiaries.</p> <p><u>Validation Documentation:</u> Documented use of evidence-based decision aids to support shared decision-making, a collaborative process aimed at improving beneficiary-clinician communication and informed consent in healthcare. Include the following element:</p> <p>1) Use of decision-aids – Documentation (e.g., checklist, algorithms, tools, screenshots) showing the use of evidence-based decision aids (e.g., https://decisionaid.ohri.ca/AZlist.html and https://shareddecisions.mayoclinic.org/decision-aid-information/decision-aids-for-chronic-disease/) to support shared decision-making with beneficiary.</p>	2017
IA_BE_14	Beneficiary Engagement	Engage patients and families to guide improvement in the system of care	Engage patients and families to guide improvement in the system of care by leveraging digital tools for ongoing guidance and assessments outside the encounter, including the collection and use of patient data for return-	High	<p><u>Objective:</u> Use active devices and platforms to allow the patient and the clinical care team to share information on a patient's status, adherence, comprehension, and indicators of clinical concern in a timely manner.</p> <p><u>Validation Documentation:</u> Evidence of engagement</p>	2017

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			to-work and patient quality of life improvement. Platforms and devices that collect patient-generated health data (PGHD) must do so with an active feedback loop, either providing PGHD in real or near-real time to the care team, or generating clinically endorsed real or near-real time automated feedback to the patient, including patient reported outcomes (PROs). Examples include patient engagement and outcomes tracking platforms, cellular or web-enabled bi-directional systems, and other devices that transmit clinically valid objective and subjective data back to care teams. Because many consumer-grade devices capture PGHD (for example, wellness devices), platforms or devices eligible for this improvement activity must be, at a minimum, endorsed and offered clinically by care teams to patients to automatically send ongoing		with patients and families by using digital tools for ongoing guidance and assessments outside the encounter. Include both of the following elements: 1) Use of digital tool or platform – Documentation of the practice’s adoption of an endorsed clinical tool or platform for digital collection and use of patient data that can create an active feedback loop between patient and clinical care team (e.g., license for tool/platform); AND 2) Collection of patient-generated health data (PGHD) and participation in active feedback loop with patients – Documentation of PGHD submission in real- or near-real-time to the care team, or reports generating clinically endorsed real- or near-real-time automated feedback to the patient, including patient reported outcomes (PROs); may be used for patients and families who need additional support because of disability or plans to improve their quality of life or return to work.	

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			guidance (one way). Platforms and devices that additionally collect PGHD must do so with an active feedback loop, either providing PGHD in real or near-real time to the care team, or generating clinically endorsed real or near-real time automated feedback to the patient (e.g. automated patient-facing instructions based on glucometer readings). Therefore, unlike passive platforms or devices that may collect but do not transmit PGHD in real or near-real time to clinical care teams, active devices and platforms can inform the patient or the clinical care team in a timely manner of important parameters regarding a patient's status, adherence, comprehension, and indicators of clinical concern.			
IA_BE_15	Beneficiary Engagement	Engagement of patients, family and caregivers in developing a plan of care	Engage patients, family, and caregivers in developing a plan of care and prioritizing their goals for action, documented in the	Medium	<p><u>Objective:</u> Increase engagement with patients, family, and caregivers and ensure care provided aligns with their priorities and needs.</p> <p><u>Validation Documentation:</u> Evidence of inclusion of</p>	2017

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			electronic health record (EHR) technology.		<p>patients, family, and caregivers in developing plan of care with prioritization of goals for action, as documented in the electronic health record (EHR). The eligible clinician will identify the patient population that will participate in this activity. Include the following element:</p> <p>1) Patient, family, and caregiver involvement – Report or screenshot from the EHR showing the plan of care and prioritized goals for action with notes from engagement of patients and/or their families and caregivers. May use another electronic platform to systematically capture patient preferences/value through a validated patient experience measure instrument.</p> <p><u>Example(s)</u>: An eligible oncologist chooses to implement a plan for all cancer patients with a likely lifespan of less than 3 years. The practice facilitates completion of the Qual-E validated Quality of Life instrument and incorporates results into treatment plan when possible and incorporates families and caregivers into the decision-making discussion when appropriate. This helps facilitate planning for aggressiveness of treatment, end-of-life planning (Do Not Resuscitate (DNR) orders, advance directives, etc.), and family/caregiver congruence.</p>	

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IA_BE_16	Beneficiary Engagement	Promote Self-management in Usual Care	To help patients self-manage their care, incorporate culturally and linguistically tailored evidence-based techniques for promoting self-management into usual care, and provide patients with tools and resources for self-management. Examples of evidence-based techniques to use in usual care include: goal setting with structured follow-up, Teach-back methods, action planning, assessment of need for self-management (for example, the Patient Activation Measure), and motivational interviewing. Examples of tools and resources to provide patients directly or through community organizations include: peer-led support for self-management, condition-specific chronic disease or substance use disorder self-management programs, and self-management materials.	Medium	<p><u>Objective:</u> Improve health outcomes by helping patients improve self-management.</p> <p><u>Validation Documentation:</u> Documented use of culturally and linguistically tailored evidence-based techniques to promote self-management into usual care. Include both of the following elements: 1) Patient literacy and language capture – Documentation of patient literacy level and/or language preference captured in the medical record (e.g., screenshot, electronic health record [EHR] report); AND 2) Provision of appropriate self-management care techniques – Documented use of evidence-based techniques to promote self-management into usual care (e.g., eligible clinicians' completed office visit checklist, electronic health record report of completed checklist, copies of goal-setting tools or techniques, motivational interviewing script/questions, action planning tool with patient feedback, record of condition-specific self-management coaching). Materials must be provided in a format appropriate for the patient's literacy and/or language preference.</p> <p><u>Example(s):</u> A primary care practice identifies cultural and educational variability, and associated variability</p>	2017

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					<p>in health literacy, in its patient population. To meet the needs of their patient population, the eligible practice clinicians review all self-management materials used by the practice and make changes to ensure all are written at the 6th-grade level or lower and are available in all languages needed for the patient population. If materials are not in all languages needed for patient population, the practice connects with an organization to translate the materials into languages not previously covered. Materials provided to the patient are referenced specifically in the EHR.</p> <p><u>Information:</u></p> <ul style="list-style-type: none"> • Context, recommendations, and resources on Health Literacy: https://www.aafp.org/afp/2005/0801/p463.html • Overview and resources: https://www.ahrq.gov/ncepcr/tools/self-mgmt/self.html • Center for Disease Control and Prevention's chronic disease self-management program: https://www.cdc.gov/arthritis/interventions/programs/cdsmp.htm; https://www.cdc.gov/arthritis/marketing-support/1-2-3-approach/docs/pdf/provider_fact_sheet_cdsmp.pdf • Approaches for language assistance services to 	

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					<p>patients with limited English proficiency: https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Lessons-from-the-Field.pdf</p> <ul style="list-style-type: none"> • Guide to ensure meaningful access to programs: https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Language-Access-Plan.pdf • Catalog of diabetes prevention resources tailored to various audiences: https://www.cms.gov/files/document/culturally-and-linguistically-tailored-type-2-diabetes-prevention-resource.pdf • Medicare benefits for diabetes self-management training, with links to multi-language resources: https://www.medicare.gov/coverage/diabetes-self-management-training • Find Administration for Community Living funded resources for self-management in your area: https://acl.gov/programs/aging-and-disability-networks 	
IA_BE_19	Beneficiary Engagement	Use group visits for common chronic conditions (e.g., diabetes)	Use group visits for common chronic conditions (e.g., diabetes).	Medium	<p><u>Objective:</u> Give patients with common chronic conditions opportunities to learn about self-management topics and discuss shared concerns while improving efficiency in the delivery of quality care.</p>	2017

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
					<p><u>Validation Documentation:</u> Documented use of group visits for chronic conditions. Could be supported by claims. Include the following element:</p> <p>1) Provision of group visit(s) – Medical claims or referrals showing group visit and chronic condition codes in conjunction with care provided.</p> <p><u>Information:</u> https://www.aafp.org/about/policies/all/shared-medical-appointments.html</p>	
IA_BE_22	Beneficiary Engagement	Improved practices that engage patients pre-visit	Implementation of workflow changes that engage patients prior to the visit, such as a pre-visit development of a shared visit agenda with the patient, or targeted pre-visit laboratory testing that will be resulted and available to the MIPS eligible clinician to review and discuss during the patient's appointment.	Medium	<p><u>Objective:</u> Increase the efficiency and effectiveness of visit time with patients, and promote patient engagement and satisfaction with care.</p> <p><u>Validation Documentation:</u> Evidence that a pre-visit agenda was shared and/or developed with patients prior to visit. Include at least one of the following elements:</p> <p>1) Pre-visit communication with patient – Documentation of communication with patient (letter, email, discussion, portal screenshot, etc.) that shows a pre-visit agenda was shared with and/or developed with the patient; OR</p> <p>2) Patient engagement workflow – Documentation of the practice's patient engagement workflow clearly showing pre-visit agenda sharing process (e.g., staff</p>	2017

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					responsible, timing, method of sharing); OR 3) Co-creation of visit agenda – Documented strategies to engage patients and their family members to co-create a visit agenda (e.g., workflow diagram, policy or process document).	
IA_BE_23	Beneficiary Engagement	Integration of patient coaching practices between visits	Provide coaching between visits with follow-up on care plan and goals.	Medium	<p><u>Objective:</u> Provide additional direct support to patients in achieving their goals, thus improving patient satisfaction, adherence to plans, and health outcomes.</p> <p><u>Validation Documentation:</u> Documented use of coaching provided between visits with follow-up on care plan and goals, for a population of the eligible clinician's choosing (e.g., patients with a specific condition). Include the population identified for this activity and at least one of the following elements: 1) Use of coaching codes – Medical claims with codes for coaching provided between visits; OR 2) Coaching plan and goals – Copy of documentation provided to patients (e.g., letter, email, portal screenshot) that includes coaching on care plan and goals; OR 3) Coaching tools used – Examples of coaching tools used by staff (e.g., coaching scripts, tools, materials).</p> <p><u>Information:</u> Clinician coaching</p>	2017

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					https://clinicalhealthcoach.com/coaching-conversation-example/	
IA_BE_24	Beneficiary Engagement	Financial Navigation Program	In order to receive credit for this activity, MIPS eligible clinicians must attest that their practice provides financial counseling to patients or their caregiver about costs of care and an exploration of different payment options. The MIPS eligible clinician may accomplish this by working with other members of their practice (for example, financial counselor or patient navigator) as part of a team-based care approach in which members of the patient care team collaborate to support patient-centered goals. For example, a financial counselor could provide patients with resources with further information or support options, or facilitate a conversation with a patient or caregiver that could address concerns. This activity may occur during diagnosis stage, before treatment, during	Medium	<p><u>Objective:</u> Help patients navigate the stress and risks associated with paying for healthcare, and, when relevant, help them explore alternative options that address their holistic needs.</p> <p><u>Validation Documentation:</u> Demonstration that the practice provides patients with estimates of the costs of the types of healthcare services it will furnish in advance (for services that can be scheduled in advance) and financial counseling to patients or their caregivers about payment options. Financial counseling may occur during diagnosis stage, before treatment, during treatment, and/or during survivorship planning, as appropriate. Include both of the following elements:</p> <p>1) Estimated cost of care provided – Documentation that an estimate of the cost to the patient of the types of healthcare services to be furnished by the eligible clinician(s) was provided to patient in advance (for services that can be scheduled in advance); AND</p> <p>2) Financial counseling provided – Documentation of financial counseling provided to patients and/or their caregivers about costs of care with evidence that different payment options were provided.</p>	2019

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			treatment, and/or during survivorship planning, as appropriate.			
IA_BE_25	Beneficiary Engagement	Drug Cost Transparency	Provide counseling to patients and/or their caregivers regarding: costs of medications using a real time benefit tool (RTBT) which provides to the prescriber real-time patient-specific formulary and benefit information for drugs, including cost-sharing for a beneficiary.	High	<p><u>Objective:</u> Help patients navigate the stress and risks associated with paying for healthcare by providing information on the patients' share of the costs for medications in the drug formulary; help patients explore alternative options that address their holistic needs.</p> <p><u>Validation Documentation:</u> Documented provision of counseling to patients and/or their caregivers regarding the costs of medications using the Real-Time Benefit Tool (RTBT). Include both of the following elements:</p> <p>1) Use of RTBT – Evidence of RTBT used in practice (e.g., workflow diagram, screenshot of tool) to provide real-time patient-specific formulary and benefit information for medications, including cost-sharing for a beneficiary and counselling on medication costs; AND</p> <p>2) Discussion of alternative medications and assistance programs – Documentation (e.g., EHR or medical record note) of discussion/counseling with patients about the availability of any alternative medications (such as generics) and the patients'</p>	2020

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
					<p>eligibility for patient assistance programs that provide free medications for patients who are unable to afford to buy their medicine. For this activity, patient assistance programs pertain to patients who require assistance to purchase necessary medications</p> <p><u>Information:</u></p> <ul style="list-style-type: none"> • Real-time benefit tool (RTBT): www.covermymeds.com/main/insights/rtbc-scorecard/ • Patient Assistance Program Center: www.rxassist.org/providers 	
IA_PSPA_1	Patient Safety & Practice Assessment	Participation in an AHRQ-listed patient safety organization	Participation in an AHRQ-listed patient safety organization.	Medium	<p><u>Objective:</u> Adopt and implement Patient Safety Organization (PSO) methodologies through data collection, analysis, reporting, and education to promote the quantifiable reduction of avoidable medical errors and deficiencies identified in the quality of care provided.</p> <p><u>Validation Documentation:</u> Evidence of participation in an Agency for Healthcare Research and Quality (AHRQ)-listed PSO. Include the following element:</p> <p>1) Confirmation of participation – Documentation from an AHRQ-listed PSO confirming the eligible clinician or group's participation with the PSO (e.g., welcome email or other communication).</p>	2017

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
					<p><u>Note:</u> PSOs listed by AHRQ are located at http://www.pso.ahrq.gov/listed, and information regarding how to choose a PSO can be found at https://pso.ahrq.gov/work-with/choose.</p>	
IA_PSPA_2	Patient Safety & Practice Assessment	Participation in MOC Part IV	<p>In order to receive credit for this activity, a MIPS eligible clinician must participate in Maintenance of Certification (MOC) Part IV. Maintenance of Certification (MOC) Part IV requires clinicians to perform monthly activities across practice to regularly assess performance by reviewing outcomes addressing identified areas for improvement and evaluating the results.</p> <p>Some examples of activities that can be completed to receive MOC Part IV credit are: the American Board of Internal Medicine (ABIM) Approved Quality Improvement (AQI) Program, National Cardiovascular Data Registry (NCDR) Clinical Quality Coach,</p>	Medium	<p><u>Objective:</u> Maintain certifications with a Maintenance of Certification (MOC)-approved specialty board to increase/update knowledge and apply it to practice and safety improvements.</p> <p><u>Validation Documentation:</u> Evidence of participation in MOC Part IV. Include the following element: 1) Confirmation of participation – Documentation of participation in MOC Part IV.</p> <p><u>Information:</u> Review appropriate information within the appropriate board certifying entity as it relates to MOC IV.</p>	2017

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
			Quality Practice Initiative Certification Program, American Board of Medical Specialties Practice Performance Improvement Module or American Society of Anesthesiologists (ASA) Simulation Education Network, for improving professional practice including participation in a local, regional or national outcomes registry or quality assessment program; specialty- specific activities including Safety Certification in Outpatient Practice Excellence (SCOPE); American Psychiatric Association (APA) Performance in Practice modules.			
IA_PSPA_3	Patient Safety & Practice Assessment	Participate in IHI Training/Forum Event; National Academy of Medicine, AHRQ Team STEPPS® or other similar activity	For MIPS eligible clinicians not participating in Maintenance of Certification (MOC) Part IV, new engagement for MOC Part IV, such as the Institute for Healthcare Improvement (IHI) Training/Forum Event; National Academy of Medicine, Agency for Healthcare Research and Quality (AHRQ) Team	Medium	<p><u>Objective:</u> Obtain a Maintenance of Certification (MOC)-approved specialty board certification or other similar program to increase/update knowledge and apply it to practice and safety improvements.</p> <p><u>Validation Documentation:</u> Evidence of participation in Institute for Healthcare Improvement (IHI) Training/Forum Event: National Academy of Medicine, AHRQ Team STEPPS®, or other similar activity. Include</p>	2017

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
			STEPPS®, or the American Board of Family Medicine (ABFM) Performance in Practice Modules.		the following element: 1) Certificate of participation – Certificate or letter of participation from an IHI Training/Forum Event: National Academy of Medicine, AHRQ Team STEPPS®, or the American Board of Family Medicine Performance in Practice Modules, or other similar activity, for eligible clinicians or groups not participating in MOC Part IV.	
IA_PSPA_4	Patient Safety & Practice Assessment	Administration of the AHRQ Survey of Patient Safety Culture	Administration of the AHRQ Survey of Patient Safety Culture and submission of data to the comparative database (refer to AHRQ Survey of Patient Safety Culture website http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/index.html). Note: This activity may be selected once every 4 years, to avoid duplicative information given that some of the modules may change on a year by year basis but over 4 years there would be a reasonable expectation for the set of modules to have undergone substantive change, for the	Medium	<u>Objective:</u> Create the opportunity to i) Raise staff awareness about patient safety; ii) Elucidate and assess the current status of patient safety culture; iii) Identify strengths and areas for patient safety culture improvement; iv) Evaluate trends in patient safety culture change over time; and v) Evaluate the cultural impact of patient safety initiatives and interventions (from https://www.ahrq.gov/sops/about/faq.html#Q1). <u>Validation Documentation:</u> Evidence of administration of the Agency for Healthcare Research and Quality (AHRQ) survey of Patient Safety Culture and submission of data to the comparative database. Include the following element: 1) Survey results data submission – Survey results from the AHRQ Survey of Patient Safety Culture, including proof of administration and submission.	2017

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
			improvement activities performance category score.		<p><u>Information:</u> https://www.ahrq.gov/sops/index.html</p> <p><u>Note:</u> This activity may be selected once every 4 years to avoid duplicative information, given that only some of the modules may change on a yearly basis; over 4 years there is a reasonable expectation for the set of modules to have undergone substantive change. Also: AHRQ's databases are only open for data submission every other year. AHRQ accepts data that have been administered between submission dates, so, <i>for example</i>, you would be able to submit August 2022 survey data in September 2023; healthcare organizations that have administered the survey between November 2021 through October 2023 will next be able to submit their data in September 2023.</p>	
IA_PSPA_7	Patient Safety & Practice Assessment	Use of QCDR data for ongoing practice assessment and improvements	<p>Participation in a Qualified Clinical Data Registry (QCDR) and use of QCDR data for ongoing practice assessment and improvements in patient safety, including:</p> <ul style="list-style-type: none"> • Performance of activities that promote use of standard practices, tools, and processes for quality improvement (for example, documented preventive health 	Medium	<p><u>Objective:</u> Use qualified clinical data registry (QCDR) data for practice assessment and improvement with primary goal of addressing patient safety for targeted populations.</p> <p><u>Validation Documentation:</u> Documented use of QCDR data for ongoing practice assessment and improvements in patient safety. Include both of the following elements:</p> <p>1) Use of QCDR for assessment – Feedback reports</p>	2017

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
			<p>efforts, like screening and vaccinations) that can be shared across MIPS eligible clinicians or groups);</p> <ul style="list-style-type: none"> • Use of standard questionnaires for assessing improvements in health disparities related to functional health status (for example, use of Seattle Angina Questionnaire, MD Anderson Symptom Inventory, and/or SF-12/VR-12 functional health status assessment); • Use of standardized processes for screening for drivers of health, such as food security, housing stability, and transportation accessibility; • Generation and use of regular feedback reports that summarize local practice patterns and treatment outcomes, including for populations that are disadvantaged and/or underserved by the healthcare system; • Use of processes and tools that engage patients to improve 		<p>provided by the QCDR that demonstrate ongoing practice assessments in patient safety; AND</p> <p>2) Use of QCDR for improvement – Documentation of how the practice is using QCDR data and documentation of intended improvements in patient safety for the specific populations targeted (e.g., documentation of standard tools, processes for screening, use of standard questionnaires, or use of QCDR data that are used for quality improvement, such as population-level analysis to assess for adverse outcomes).</p> <p><u>Example(s)</u>: An anesthesia group is supported by a QCDR for quality improvement and MIPS reporting. The QCDR provides routine data feedback reports to the eligible clinicians as part of the engagement. In one of the areas of review, the anesthesiologists realize, through the provided data, that they are inconsistently providing appropriately timed dosing of neuromuscular blocker recovery medication. This creates significant potential for complications at the time of extubation following the procedure. As a result, the anesthesiology group develops a plan that includes checklists to prevent this problem moving forward and they successfully eliminate the safety risk.</p>	

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
			<p>adherence to treatment plans;</p> <ul style="list-style-type: none"> • Implementation of patient self-action plans; • Implementation of shared clinical decision-making capabilities; • Use of QCDR patient experience data to inform and advance improvements in beneficiary engagement; • Promotion of collaborative learning network opportunities that are interactive; • Use of supporting QCDR modules that can be incorporated into the certified EHR technology; OR • Use of QCDR data for quality improvement, such as comparative analysis across specific patient populations of adverse outcomes after an outpatient surgical procedure and corrective steps to address these outcomes. 			
IA_PSPA_8	Patient Safety & Practice Assessment	Use of patient safety tools	In order to receive credit for this activity, a MIPS eligible clinician must use tools that assist specialty practices in tracking specific	Medium	<u>Objective:</u> Improve the number of patients tracked and the precision of measurement for patient safety measures, thus allowing specialists to make evidence-based decisions about improving safety for their	2017

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
			<p>measures that are meaningful to their practice.</p> <p>Some examples of tools that could satisfy this activity are: a surgical risk calculator; evidence based protocols, such as Enhanced Recovery After Surgery (ERAS) protocols; the Centers for Disease Control (CDC) Guide for Infection Prevention for Outpatient Settings predictive algorithms; and the opiate risk tool (ORT) or similar tool.</p>		<p>patients.</p> <p><u>Validation Documentation:</u> Documented use of patient safety tools implemented for tracking specific patient safety and practice assessment measures that are meaningful to the eligible clinician or group (e.g., tracking HbA1c would be meaningful to an endocrinologist whereas tracking intraocular pressure would be more meaningful to an ophthalmologist). Include both of the following elements:</p> <p>1) Evidence of safety tools used – Documentation of the use of patient safety tools that assist in tracking patient safety measures (e.g., practice policy or protocol, workflow diagram, screenshot); AND</p> <p>2) Evidence of measures tracked – Documentation of specific patient safety measures tracked via use of tool (e.g., quality measure report, dashboard, screenshot).</p> <p><u>Example(s):</u></p> <ul style="list-style-type: none"> • Surgical risk calculator • Opiate risk tool • The Centers for Disease Control and Prevention (CDC) Guide for Infection Prevention for Outpatient Settings predictive algorithms. • Use of clinical assessment modalities and diagnostic screening tools in specialty medicine (e.g., World 	

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
					<p>Health Organization's Fracture Risk Assessment (FRAX) Tool);</p> <ul style="list-style-type: none"> • Use American College of Cardiology Surviving myocardial infarction (MI) • Use American College of Physicians (ACP) Practice Advisor; ACP Quality Connect; • Conduct Disease Activity Measurement to Optimize Treating to Target; • Improve Informed Consent and Shared Decision-Making with Evidence-Based Risk Stratification Strategies; • Implement American Gastroenterological Association Clinical Guidelines Mobile App; • Participate in public health emergency disease outbreak control efforts; • Participate in voluntary surveillance activity; • Conduct population management strategies within a Perioperative Surgical Home; • Use of American Urological Association Symptom Index to increase patient engagement; • Provide leadership of Infection Prevention and Control Program; • Conduct therapeutic drug monitoring for inflammatory bowel disease patients that are on anti-tumor necrosis factor (TNF) therapies; • Deploy predictive analytical models to manage 	

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
					chronic disease in patients; • Perform review of Enhanced Recovery after Surgery protocol and implement improvement plan.	
IA_PSPA_9	Patient Safety & Practice Assessment	Completion of the AMA STEPS Forward program	Completion of the American Medical Association's STEPS Forward program.	Medium	<p><u>Objective:</u> Gain the knowledge to "improve practice efficiency and ultimately enhance patient care, physician satisfaction and practice sustainability" (from https://edhub.ama-assn.org/steps-forward/pages/About).</p> <p><u>Validation Documentation:</u> Evidence of completion of American Medical Association's (AMA's) STEPS Forward program. Include at least one of the following elements: 1) Certificate of completion – Certificate of completion from at least one AMA's STEPS Forward program module; OR 2) Evidence of implementation – Documentation of newly implemented care processes based on completion of AMA's STEPS Forward module.</p>	2017
IA_PSPA_12	Patient Safety & Practice Assessment	Participation in private payer CPIA	Participation in designated private payer clinical practice improvement activities.	Medium	<p><u>Objective:</u> Improve the quality of care provided, and health outcomes for patients, by participating in improvement activities designated by private payers.</p> <p><u>Validation Documentation:</u> Evidence of participation in private payer clinical practice improvement activities. Include the following element:</p>	2017

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
					1) Confirmation of participation – Documents showing participation in private payer clinical practice improvement activities (e.g., quality measure documentation or feedback reports, practice workflow redesign tools developed for or with the payer as part of practice improvement).	
IA_PSPA_13	Patient Safety & Practice Assessment	Participation in Joint Commission Evaluation Initiative	Participation in Joint Commission Ongoing Professional Practice Evaluation initiative	Medium	<p><u>Objective:</u> Implement the Joint Commission's Ongoing Professional Practice Evaluation with goal of identifying negative practice trends earlier.</p> <p><u>Validation Documentation:</u> Evidence of participation in the Joint Commission's Ongoing Professional Practice Evaluation (OPPE) initiative. Include the following element:</p> <p>1) Confirmation of participation – Documentation from Joint Commission's OPPE initiative confirming participation in its improvement program(s) (e.g., email or other communication).</p>	2017
IA_PSPA_15	Patient Safety & Practice Assessment	Implementation of an ASP	Leadership of an Antimicrobial Stewardship Program (ASP) that includes implementation of an ASP that measures the appropriate use of antibiotics for several different conditions (such as but not limited to upper respiratory infection treatment in children, diagnosis of	Medium	<p><u>Objective:</u> Reduce inappropriate use of antimicrobials, thus playing a critical role in reducing microbial resistance and the incidence of antimicrobial-caused adverse drug reactions, all of which will help improve patient outcomes and the efficiency of spending.</p> <p><u>Validation Documentation:</u> Evidence of leadership of an Antimicrobial Stewardship Program (ASP) that</p>	2017

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
			<p>pharyngitis, bronchitis treatment in adults) according to clinical guidelines for diagnostics and therapeutics. Specific activities may include:</p> <ul style="list-style-type: none"> • Develop facility-specific antibiogram and prepare report of findings with specific action plan that aligns with overall facility or practice strategic plan. • Lead the development, implementation, and monitoring of patient care and patient safety protocols for the delivery of ASP including protocols pertaining to the most appropriate setting for such services (i.e., outpatient or inpatient). • Assist in improving ASP service line efficiency and effectiveness by evaluating and recommending improvements in the management structure and workflow of ASP processes. • Manage compliance of the ASP policies and assist with 		<p>measures the appropriate use of antibiotics for several different conditions according to clinical guidelines for diagnostics and therapeutics. Include at least one of the following elements:</p> <p>1) Antibiogram and report – Documented facility-specific antibiogram and report of findings and specific action plan aligned with overall facility or practice strategic plan; OR</p> <p>2) ASP patient care and safety protocols – Documentation of the development, implementation, and monitoring of patient care and safety protocols as a result of the process of operating the ASP (e.g., email communication, meeting agendas with eligible clinician's name, staff confirmation); OR</p> <p>3) ASP evaluation – Documentation of the on-going evaluation and monitoring of the management structure and workflow of ASP processes and involvement therein (e.g., email communication, meeting agendas with eligible clinician's name, reports, staff confirmation); OR</p> <p>4) ASP education and training – Records of presentation of ASP education and training including curriculum and presentation dates with eligible clinician named as one of the facilitators or presenters; OR</p> <p>5) ASP policies or practices for high-priority</p>	

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
			<p>implementation of corrective actions in accordance with facility or clinic compliance policies and hospital medical staff by-laws.</p> <ul style="list-style-type: none"> • Lead the education and training of professional support staff for the purpose of maintaining an efficient and effective ASP. • Coordinate communications between ASP management and facility or practice personnel regarding activities, services, and operational/clinical protocols to achieve overall compliance and understanding of the ASP. • Assist, at the request of the facility or practice, in preparing for and responding to third-party requests, including but not limited to payer audits, governmental inquiries, and professional inquiries that pertain to the ASP service line. • Implementing and tracking an evidence-based policy or practice aimed at improving antibiotic prescribing practices for high- 		<p>conditions – Documentation of involvement in selecting and implementing evidence-based policy or practice aimed at improving antibiotic prescribing practices for high-priority conditions; OR</p> <p>6) ASP protocols and decision supports – Documentation of developing and implementing evidence-based protocols and decision-support for diagnosis and treatment of common infections; OR</p> <p>7) Alignment with CDC Core Elements of Outpatient Antibiotic Stewardship guidance – Documentation of involvement in the alignment of evidence-based protocols with recommendations in the Centers for Disease Control and Prevention’s (CDC’s) Core Elements of Outpatient Antibiotic Stewardship guidance.</p> <p><u>Information:</u> Extensive information on antimicrobial stewardship can be found at the CDC website: https://www.cdc.gov/antibiotic-use/core-elements/index.html. Also, the CDC includes information on ASPs for different practice settings (hospital, outpatient, nursing home, etc.).</p>	

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
			<p>priority conditions.</p> <ul style="list-style-type: none"> • Developing and implementing evidence-based protocols and decision-support for diagnosis and treatment of common infections. • Implementing evidence-based protocols that align with recommendations in the Centers for Disease Control and Prevention's Core Elements of Outpatient Antibiotic Stewardship guidance. 			
IA_PSPA_16	Patient Safety & Practice Assessment	Use of decision support and standardized treatment protocols	Use decision support and standardized treatment protocols to manage workflow in the team to meet patient needs.	Medium	<p><u>Objective:</u> Help eligible clinicians align diagnoses and treatment plans with up-to-date, evidence-based standards and guidelines as part of routine care, thus improving the appropriateness of the care they provide and the health outcomes of their patients.</p> <p><u>Validation Documentation:</u> Documented use of decision support and standardized treatment protocols to manage team workflows to meet patient needs. Include the following element:</p> <p>1) Use of decision support and standardized treatment protocols – Documentation (e.g., checklist, order set, algorithm, screenshot) demonstrating use of decision support and standardized treatment</p>	2017

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					<p>protocols to manage team workflows to meet patient needs. May include use of artificial intelligence/machine learning.</p> <p><u>Example(s)/Information:</u> An eligible clinician group, through peer review, determines that there is significant variability in clinical decision-making for a specific condition. They all agree that standardization of practice is best for patient outcomes. Examples of scenarios:</p> <ul style="list-style-type: none"> • Emergency Department (ED) treatment of ST elevation Myocardial Infarction (MI): ED staff develop MI standardized orders (order-set) built into the electronic health record (EHR) workflow. The order-set drives specific evaluation and treatment decisions and automatically pages the cardiac catheterization lab and the on-call cardiologist. • Pediatrics primary care office treatment of subcutaneous/skin abscess: Through discussion among peers in a small pediatrics office, the eligible clinicians determine that there is variability in the decision to implement an abscess incision and drainage versus only using antibiotics and there is also variability in the antibiotic used. As a result, they created internal guidelines on how to approach skin infections and antibiotic treatment and, in particular, addressing 	

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					<p>methicillin-resistant staphylococcus aureus (MRSA).</p> <ul style="list-style-type: none"> • Opiate prescribing: An eligible general surgeon group completed an internal review of opiate prescribing and learned that there was opportunity to reduce the use of opiates significantly. As a result, they created an order-set within their EHR. The use of the order-set was mandatory for all opiate prescribing and created limits for quantity based on condition. The prescribing surgeon could always make an independent treatment decision as needed. 	
IA_PSPA_17	Patient Safety & Practice Assessment	Implementation of analytic capabilities to manage total cost of care for practice population	In order to receive credit for this activity, a MIPS eligible clinician must conduct or build the capacity to conduct analytic activities to manage total cost of care for the practice population. Examples of these activities could include: 1.) Train appropriate staff on interpretation of cost and utilization information; 2.) Use available data regularly to analyze opportunities to reduce cost through improved care. An example of a platform with the necessary analytic capability to do this is the American Society for	Medium	<p><u>Objective:</u> Create opportunities to assess total cost of care and identify ways to reduce unnecessary costs.</p> <p><u>Validation Documentation:</u> Evidence of use or building of analytic capabilities to manage the total cost of care for the practice population. Include at least one of the following elements: 1) Staff training – Documentation of staff training on interpretation of cost and utilization information (e.g., training documentation); OR 2) Cost/resource use data – Availability of cost/resource use data for the practice population that the practice uses regularly to analyze opportunities to reduce cost; OR 3) Participation in regional Total Cost of Care efforts – Engage with local Regional Health Improvement</p>	2017

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
			Gastrointestinal (GI) Endoscopy's GI Operations Benchmarking Platform.		<p>Collaborative (RHIC) to measure and utilize Total Cost of Care (TCoC) to identify opportunities for practice improvement, create a practice improvement plan(s), and execute on the plan(s). Documentation may include communication with RHIC (e.g., email) or a copy of TCoC report(s).</p> <p><u>Example(s)/Information:</u></p> <ul style="list-style-type: none"> • The American Society for Gastrointestinal (GI) Endoscopy's GI Operations Benchmarking Platform is an example of a tool used for identifying opportunities to reduce cost: https://www.asge.org/home/practice-support/gi-operations-benchmarking • The Network for Regional Healthcare Improvement representing regional healthcare collaboratives has information about TCoC: https://www.nrhi.org/ 	
IA_PSPA_18	Patient Safety & Practice Assessment	Measurement and improvement at the practice and panel level	<p>Measure and improve quality at the practice and panel level, such as the American Board of Orthopaedic Surgery (ABOS) Physician Scorecards that could include one or more of the following:</p> <ul style="list-style-type: none"> • Regularly review measures of quality, utilization, patient satisfaction and other measures; 	Medium	<p><u>Objective:</u> Enhance the measurement of the quality of care, making quality data relevant at practice and panel levels, and use those data to implement effective quality improvement activities.</p> <p><u>Validation Documentation:</u> Evidence of quality measurement and improvement for populations at the practice and panel level or for specific populations (e.g., racial and ethnic minorities, individuals with disabilities, sexual and gender minorities, individuals</p>	2017

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
			<p>and/or</p> <ul style="list-style-type: none"> • Use relevant data sources to create benchmarks and goals for performance at the practice or panel levels. <p>MIPS eligible clinicians can apply the measurement and quality improvement to address inequities in quality and outcomes for underserved populations, including racial, ethnic, and/or gender minorities.</p>		<p>with certain chronic conditions/risk factors, or individuals in rural areas). Include at least one of the following elements:</p> <p>1) Performance benchmarks and goals – Performance benchmarks and goals to drive overall improvements; OR</p> <p>2) Quality improvement program/plan at practice and panel level – Copy of a quality improvement program/plan or review of quality, utilization, patient satisfaction (surveys should be administered by a third-party survey administrator/vendor), and other measures to improve one or more elements of this activity; OR</p> <p>3) Review of and progress on measures – Report showing progress on selected measures, including benchmarks and goals for performance using relevant data sources at the practice and panel level.</p> <p><u>Example(s):</u></p> <ul style="list-style-type: none"> • Obtain diagnostic Imaging Center of Excellence (DICOE) designation • Participate in Endoscopy Unit Recognition Program (EURP) • Participate in Simulation Education Courses approved by the American Society of Anesthesiologist's Simulation Education Network 	

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
					<ul style="list-style-type: none"> • Use the Centers for Medicare & Medicaid Services' Disparities Impact Statement tool to fulfill this activity and address inequities in quality and outcomes for underserved and vulnerable populations <p><u>Information:</u></p> <ul style="list-style-type: none"> • Toolkit for implementing Culturally and Linguistically Appropriate Services Standards: https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/CLAS-Toolkit-12-7-16.pdf 	
IA_PSPA_19	Patient Safety & Practice Assessment	Implementation of formal quality improvement methods, practice changes or other practice improvement processes	<p>Adopt a formal model for quality improvement and create a culture in which all staff, including leadership, actively participates in improvement activities that could include one or more of the following, such as:</p> <ul style="list-style-type: none"> • Participation in multisource feedback; • Train all staff in quality improvement methods; • Integrate practice change/quality improvement into staff duties; • Engage all staff in identifying and testing practices changes; 	Medium	<p><u>Objective:</u> Expand and formalize quality improvement (QI) activities across the practice, ultimately leading to improvements in the quality of care and fostering a culture of participation among staff, including leadership.</p> <p><u>Validation Documentation:</u> Evidence of the implementation of a formal plan for QI and creation of a culture in which staff actively participates in one or more applicable QI activities. This activity allows MIPS clinicians to build the foundations for other activities they pursue in the future. Include both of the following elements:</p> <p>1) Adopt formal quality improvement plan and create culture of improvement – Documentation of adoption</p>	2017

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
			<ul style="list-style-type: none"> • Designate regular team meetings to review data and plan improvement cycles; • Promote transparency and accelerate improvement by sharing practice level and panel level quality of care, patient experience and utilization data with staff; • Promote transparency and engage patients and families by sharing practice level quality of care, patient experience and utilization data with patients and families, including activities in which clinicians act upon patient experience data; • Participation in Bridges to Excellence; • Participation in American Board of Medical Specialties (ABMS) Multi-Specialty Portfolio Program. 		<p>of a formal model for QI and creation of a culture in which staff actively participate in QI activities. Formal QI models are used by eligible clinicians to develop systems, tools, and interventional strategies to improve processes of care for their patient population; AND</p> <p>2) Staff participation – Documentation of staff participation in one or more of the 6 key areas for improvement*: a) training; b) integration into staff duties; c) identifying and testing practice changes; d) regular team meetings to review data and plan improvement cycles; e) share practice and panel level quality of care; f) patient experience and utilization data with staff; or g) share practice level quality of care, patient experience and utilization data with patients and families.</p> <p>The following elements are suggested regarding the essential engagement of leadership in quality improvement:</p> <p>1) Time for leadership in improvement efforts – Documentation of allocated time for clinical and administrative leadership participating in improvement efforts (e.g., regular team meeting agendas and post meeting summaries); OR</p> <p>2) Clinical and administrative leadership role</p>	

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
					<p>descriptions – Documentation of clinical and administrative leadership role descriptions that include responsibility for practice improvement change (e.g., position description)</p> <p><u>Example(s)</u>: A cardiology or multi-specialty practice seeks to institute changes to improve the management of patients with elevated low-density lipoprotein cholesterol (LDL-C), which is associated with higher risk of heart disease. The practice develops and implements a formal quality improvement plan with the goals of appropriately identifying, engaging, treating, and monitoring patients with elevated cholesterol. To achieve these goals, the practice takes the following steps:</p> <ul style="list-style-type: none"> • Methodically identify patients who would benefit from initiating or intensifying lipid-lowering therapy • Implement a systematic effort to increase the proportion of patients who reach threshold LDL-C levels defined in evidence-based guidelines—e.g. by implementing automated scheduling, enhanced use of office screening protocols, flags/alerts in the electronic health record system, clinical team reviews of health plan/patient care gaps • Measure impact through routine follow-up visits and LDL-C testing 	

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					<p><u>Information:</u></p> <ul style="list-style-type: none"> • *Report with 6 key areas for focus in healthcare quality improvement: http://www.ihi.org/resources/Pages/Publications/CrossingtheQualityChasmANewHealthSystemforthe21stCentury.aspx • "Model for Improvement" on improvement plan focused for eligible clinician/practices and their patients: http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx • The American Academy of Dermatology Quality Innovation Center Collaborative 	
IA_PSPA_21	Patient Safety & Practice Assessment	Implementation of fall screening and assessment programs	Implementation of fall screening and assessment programs to identify patients at risk for falls and address modifiable risk factors (e.g., Clinical decision support/prompts in the electronic health record that help manage the use of medications, such as benzodiazepines, that increase fall risk).	Medium	<p><u>Objective:</u> Improve identification of patients who are at risk of falling; then reduce their risk and improve their health outcome, independence, and satisfaction with care.</p> <p><u>Validation Documentation:</u> Documented implementation of fall screening and assessment programs. Include at least one of the following elements:</p> <p>1) Implementation of a falls screening and assessment program – Documentation of newly implemented falls screening and assessment program</p>	2017

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					<p>that uses valid and reliable tools to identify patients at risk for falls and address modifiable risk factors (e.g., clinical decision support (CDS)/prompts in the electronic health record (EHR) that help manage the use of medications, such as benzodiazepines, that increase fall risk). The program population should be defined by the eligible clinicians (e.g., all patients over a certain age); OR</p> <p>2) Implementation progress – Documentation of follow-up after falls screening and assessment with focus on improvement in risk factors. Documentation of follow-up may include: follow-up screening, notes or medication list demonstrating mitigation of the risk or other health record data demonstrating follow-up, etc.</p> <p><u>Example(s)/Information:</u> Implementation of the Centers for Disease Control and Prevention’s Stopping Elderly Accidents, Deaths, and Injuries (CDC STEADI) program for identification of falls risk and actions to take to mitigate falls. https://www.cdc.gov/steady/about.html</p>	
IA_PSPA_22	Patient Safety & Practice Assessment	CDC Training on CDC's Guideline for Prescribing	Completion of all the modules of the Centers for Disease Control and Prevention (CDC) course “Applying CDC’s Guideline for Prescribing	High	<p><u>Objective:</u> Become better equipped to improve prescription practices and thus help reduce patients' risks of addiction and overdose.</p>	2018

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		Opioids for Chronic Pain	Opioids” that reviews the 2016 “Guideline for Prescribing Opioids for Chronic Pain.” Note: This activity may be selected once every 4 years, to avoid duplicative information given that some of the modules may change on a year by year basis but over 4 years there would be a reasonable expectation for the set of modules to have undergone substantive change, for the improvement activities performance category score.		<p><u>Validation Documentation:</u> Documented completion with a passing score for all applicable modules available during the performance year of the Centers for Disease Control and Prevention’s (CDC’s) course "Applying CDC's Clinical Practice Guideline for Prescribing Opioids for Pain" that reviews the 2016/2022 "Clinical Practice Guideline for Prescribing Opioids for Pain." Include the following element:</p> <p>1) Record of completion and passing score – Documented participation in and completion of (e.g., certificate of completion, screenshot) the CDC’s course "Applying CDC's Clinical Practice Guideline for Prescribing Opioids for Pain" that reviews the 2016/2022 "Clinical Practice Guideline for Prescribing Opioids for Pain."</p> <p><u>Example(s)/Information:</u> The training can be found at the following link. CME can be obtained at no cost by following the instructions on the site. https://www.cdc.gov/drugoverdose/training/online-training.html; please note that this guideline was updated in November 2022. This guideline may be updated periodically, and the most recent available guideline should be referred to/used in completing this activity.</p>	

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IA_PSPA_23	Patient Safety & Practice Assessment	Completion of CDC Training on Antibiotic Stewardship	Completion of all modules of the Centers for Disease Control and Prevention antibiotic stewardship course. Note: This activity may be selected once every 4 years, to avoid duplicative information given that some of the modules may change on a year by year basis but over 4 years there would be a reasonable expectation for the set of modules to have undergone substantive change, for the improvement activities performance category score.	High	<p><u>Objective:</u> Reduce inappropriate use of antimicrobials to help reduce microbial resistance and the incidence of antimicrobial-caused adverse drug reactions, all of which will help improve patient outcomes and the efficiency of spending.</p> <p><u>Validation Documentation:</u> Documented completion with a passing score of all available modules of the Centers for Disease Control and Prevention's (CDC) antibiotic stewardship course. Include the following element:</p> <p>1) Record of completion and passing score – Documented participation in and completion (e.g., certificate of completion, screenshot) of all available modules of the CDC antibiotic stewardship course.</p> <p><u>Example(s)/Information:</u> https://www.train.org/cdctrain/training_plan/3697</p>	2018
IA_PSPA_25	Patient Safety & Practice Assessment	Cost Display for Laboratory and Radiographic Orders	Implementation of a cost display for laboratory and radiographic orders, such as costs that can be obtained through the Medicare clinical laboratory fee schedule.	Medium	<p><u>Objective:</u> Help eligible ordering clinicians easily obtain information on the cost of laboratory and radiography orders, allowing them to manage their costs strategically.</p> <p><u>Validation Documentation:</u> Demonstration of cost transparency by displaying costs for laboratory and radiography at the point-of-order for ordering</p>	2018

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					<p>clinicians. Include the following element:</p> <p>1) Cost display for laboratory and radiographic orders – Documentation (e.g., screenshot, report from the electronic health record, written display procedure) of laboratory and radiographic costs at the point-of-order.</p>	
IA_PSPA_26	Patient Safety & Practice Assessment	Communication of Unscheduled Visit for Adverse Drug Event and Nature of Event	<p>A MIPS eligible clinician providing unscheduled care (such as an emergency room, urgent care, or other unplanned encounter) attests that, for greater than 75 percent of case visits that result from a clinically significant adverse drug event, the MIPS eligible clinician provides information, including through the use of health IT to the patient's primary care clinician regarding both the unscheduled visit and the nature of the adverse drug event within 48 hours. A clinically significant adverse event is defined as a medication-related harm or injury such as side-effects, supratherapeutic effects, allergic reactions, laboratory abnormalities, or medication errors requiring</p>	Medium	<p><u>Objective:</u> Allow primary care doctors to immediately tailor plans of care for patients to prevent further medication errors and achieve better outcomes in the future.</p> <p><u>Validation Documentation:</u> Documentation of communication regarding clinically significant adverse drug events from the eligible clinician providing unscheduled care to the primary care clinician within 48 hours. Unscheduled care includes emergency room visit, urgent care, or other unplanned encounter. A clinically significant adverse event is defined as a medication-related harm or injury such as side-effects, supra-therapeutic effects, allergic reactions, laboratory abnormalities, or medication errors requiring urgent/emergent evaluation, treatment or hospitalization. Include all of the following elements:</p> <p>1) Documentation of the process for capturing adverse drug events; AND</p> <p>2) Details of clinically significant adverse drug event –</p>	2018

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
			urgent/emergent evaluation, treatment, or hospitalization.		<p>Documentation (e.g., medical record, chart note) of clinically significant adverse event; AND</p> <p>3) Communication of event within 48 hours – Documentation of communication of the event to the patient's primary care clinician within 48 hours of the unscheduled event (e.g., Health Information Exchange, other Health Information Technology, secure email). Communication to include both details about the unscheduled event and the nature of the adverse drug event.</p> <p><u>Example(s):</u></p> <ul style="list-style-type: none"> • A small internal medicine practice has numerous patients on warfarin. Those patients are managed by the local "Coumadin Clinic" at the hospital. Occasionally, those patients are seen in the local emergency department for bleeding, or are referred to the emergency department from the Coumadin Clinic that is testing the patients' International Normalized Ratio (INR). The hematology group partners with the emergency department clinician group to develop a process for communicating adverse warfarin reactions. They identify all appropriate diagnosis codes that could be linked to an adverse warfarin level or reaction. They work with IT to create an automatically generated email (fax, etc.) of the clinical record, 	

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					<p>triggered by the diagnosis code, and have it sent to the primary care clinician.</p> <ul style="list-style-type: none"> An emergency department clinician group creates an internal policy that all clinically significant adverse drug reactions are communicated with the eligible primary care clinician. As a result, they create a manual process that requires the emergency physician to contact the eligible primary care clinician and communicate the situation. The eligible clinicians create a specific field in the electronic health record for documenting the brief details of the communication. 	
IA_PSPA_27	Patient Safety & Practice Assessment	Invasive Procedure or Surgery Anticoagulation Medication Management	For an anticoagulated patient undergoing a planned invasive procedure for which interruption in anticoagulation is anticipated, including patients taking vitamin K antagonists (warfarin), target specific oral anticoagulants (such as apixaban, dabigatran, and rivaroxaban), and heparins/low molecular weight heparins, documentation, including through the use of electronic tools, that the plan for anticoagulation management in the periprocedural	Medium	<p><u>Objective:</u> Formalize and document a standardized process for management of patients on anti-coagulant medication before, during, and after invasive procedures, thus reducing risk of complications.</p> <p><u>Validation Documentation:</u> Create a standardized process for managing patient anti-coagulation during the peri-procedural period for planned invasive procedure for which interruption in anticoagulation is anticipated. Include all of the following elements:</p> <p>1) Identification of patients needing anticoagulation management – Documentation of a process to identify patients taking anticoagulants including vitamin K antagonists (warfarin), direct oral anticoagulants (such</p>	2018

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			period was discussed with the patient and with the clinician responsible for managing the patient's anticoagulation. Elements of the plan should include the following: discontinuation, resumption, and, if applicable, bridging, laboratory monitoring, and management of concomitant antithrombotic medications (such as antiplatelets and nonsteroidal anti-inflammatory drugs (NSAIDs)). An invasive or surgical procedure is defined as a procedure in which skin or mucous membranes and connective tissue are incised, or an instrument is introduced through a natural body orifice.		as apixaban, dabigatran, and rivaroxaban), and heparins/low molecular weight heparins for anticoagulation medication management plan; AND 2) Documented discussion – Standardized documentation (e.g., medical record note with standardized components, pre-procedural document maintained in the medical record) of specific plan for managing patient anti-coagulation before, during, and after surgery by relevant eligible clinicians (such as primary care clinician, hospitalist, surgeon, or anesthesiologist); AND 3) Examples of anti-coagulation management plans – Examples of documented plans (e.g., medical record, electronic health record, secure email) for anticoagulation management in the peri-procedural period for planned invasive procedures. The plan should include the following: discontinuation, resumption, and, if applicable, bridging medication, laboratory monitoring, and management of concomitant antithrombotic medications (such as anti-platelet and nonsteroidal anti-inflammatory drugs).	
IA_PSPA_28	Patient Safety & Practice Assessment	Completion of an Accredited Safety or Quality Improvement Program	Completion of an accredited performance improvement continuing medical education (CME) program that addresses performance or quality	Medium	<u>Objective:</u> Complete an accredited performance improvement continuing medical education (CME) program, ultimately applying program content to address a specific quality or safety gap.	2018

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
			<p>improvement according to the following criteria:</p> <ul style="list-style-type: none"> • The activity must address a quality or safety gap that is supported by a needs assessment or problem analysis, or must support the completion of such a needs assessment as part of the activity; • The activity must have specific, measurable aim(s) for improvement; • The activity must include interventions intended to result in improvement; • The activity must include data collection and analysis of performance data to assess the impact of the interventions; and • The accredited program must define meaningful clinician participation in their activity, describe the mechanism for identifying clinicians who meet the requirements, and provide participant completion 		<p><u>Validation Documentation:</u> Documented completion of an accredited performance improvement program that includes active individual participation in the completion of a performance improvement project. Include all of the following elements:</p> <p>1) Documentation/report of the performance improvement project completed – Documentation to include: a) the specific quality or safety gap and measurable improvement goal; b) the interventions used to result in improvement; and c) data with analysis demonstrating the improvement; AND</p> <p>2) Confirmation of participation – Documented confirmation of participation and completion in accredited performance improvement program; AND</p> <p>3) Program details – Details of accredited program must include: a) definition of meaningful eligible clinician participation in their activity; and b) description of the mechanism for identifying eligible clinicians who meet the requirements.</p> <p><u>Example(s)/Information:</u></p> <ul style="list-style-type: none"> • Performance Improvement Module, such as Asthma IQ: Patient Management and Outcomes, Asthma IQ: Patient Assessment, PI Pro: Food Allergy, Self-Directed Practice Improvement Module <p>https://www.aaaai.org/practice-resources/asthma-iq</p>	

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			<p>information.</p> <p>An example of an activity that could satisfy this improvement activity is completion of an accredited continuing medical education program related to opioid analgesic risk and evaluation strategy (REMS) to address pain control (that is, acute and chronic pain).</p>		<ul style="list-style-type: none"> • Participate in American Society for Gastrointestinal Endoscopy Skills Training Assessment Reinforcement (STAR) Certificate Program https://www.asge.org/home/education/advanced-education-training/star-certificate-programs • American Society of Clinical Oncology Quality Training Program https://practice.asco.org/quality-improvement/quality-programs/quality-training-program • Agency for Healthcare Research and Quality's Making Informed Consent an Informed Choice: Training for Healthcare Professionals https://www.ahrq.gov/health-literacy/professional-training/informed-choice.html • American College of Physicians Advance Quality Improvement Curriculum https://www.acponline.org/practice-resources/acp-quality-improvement/acp-advance/quality-improvement-curriculum 	
IA_PSPA_29	Patient Safety & Practice Assessment	Consulting Appropriate Use Criteria (AUC) Using Clinical Decision Support when Ordering	Clinicians attest that they are consulting specified applicable AUC through a qualified clinical decision support mechanism for all applicable imaging services furnished in an applicable setting, paid for under an applicable	High	<p><u>Objective:</u> Consult Appropriate Use Criteria (AUC) through a clinical decision support (CDS) mechanism for imaging services to reduce unnecessary and potentially harmful over-imaging.</p> <p><u>Validation Documentation:</u> Documented consultation of specified AUC through a qualified CDS mechanism</p>	2018

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
		Advanced Diagnostic Imaging	payment system, and ordered on or after January 1, 2018. This activity is for clinicians that are early adopters of the Medicare AUC program (2018 performance year) and for clinicians that begin the Medicare AUC program in future years as specified in our regulation at §414.94. The AUC program is required under section 218 of the Protecting Access to Medicare Act of 2014. Qualified mechanisms will be able to provide a report to the ordering clinician that can be used to assess patterns of image-ordering and improve upon those patterns to ensure that patients are receiving the most appropriate imaging for their individual condition.		<p>for imaging services. Include at least one of the following elements:</p> <p>1) Early adopter status – Evidence of early adoption of the Medicare AUC program (2018 Performance Year); OR</p> <p>2) Demonstration of standardized use of AUC in daily patient care – Provide reports, details of agreement with provider of services, detailed information about standardized process, etc.; OR</p> <p>3) Image-ordering reports – Copies of reports (e.g., paper copy, screenshots) sent to the ordering clinician that can be used to assess patterns of image-ordering and improve upon those patterns to ensure that patients are receiving the most appropriate imaging for their individual condition.</p> <p><u>Example(s)/Information:</u></p> <ul style="list-style-type: none"> • AUC Criteria program: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Appropriate-Use-Criteria-Program • Qualified AUC mechanisms: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Appropriate-Use-Criteria-Program/CDSM 	

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
IA_PSPA_31	Patient Safety & Practice Assessment	Patient Medication Risk Education	In order to receive credit for this activity, MIPS eligible clinicians must provide both written and verbal education regarding the risks of concurrent opioid and benzodiazepine use for patients who are prescribed both benzodiazepines and opioids. Education must be completed for at least 75% of qualifying patients and occur: (1) at the time of initial co-prescribing and again following greater than 6 months of co-prescribing of benzodiazepines and opioids, or (2) at least once per MIPS performance period for patients taking concurrent opioid and benzodiazepine therapy.	High	<p><u>Objective:</u> Educate patients regarding the risks of concurrent opioid and benzodiazepine use, thus reducing their risk of overdose.</p> <p><u>Validation Documentation:</u> Evidence of both written and verbal education regarding the risks of concurrent opioid and benzodiazepine use provided to patients who are prescribed both benzodiazepines and opioids. Include both of the following elements:</p> <p>1) Examples of education provided – Copies of written education (e.g., pamphlets, patient portal screenshot) and verbal education (e.g., scripts/descriptions of what must be said) provided; AND</p> <p>2) Education provided to patients co-prescribed – Education must be completed for at least 75% of qualifying patients and occur a) at the time of initial co-prescribing and again following greater than 6 months of co-prescribing of benzodiazepines and opioids; or b) at least once per MIPS performance period for patients taking concurrent opioid and benzodiazepine therapy.</p>	2019
IA_PSPA_32	Patient Safety & Practice Assessment	Use of CDC Guideline for Clinical Decision Support to Prescribe	In order to receive credit for this activity, MIPS eligible clinicians must utilize the Centers for Disease Control (CDC) Guideline for Prescribing Opioids for Chronic Pain	High	<p><u>Objective:</u> Make Centers for Disease Control (CDC) Clinical Practice Guideline for Prescribing Opioids for Pain via clinical decision support (CDS) part of eligible clinicians' workflow, thus improving prescription practices, protecting patients at risk for addition</p>	2019

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
		Opioids for Chronic Pain via Clinical Decision Support	via clinical decision support (CDS). For CDS to be most effective, it needs to be built directly into the clinician workflow and support decision making on a specific patient at the point of care. Specific examples of how the guideline could be incorporated into a CDS workflow include, but are not limited to: electronic health record (EHR)-based prescribing prompts, order sets that require review of guidelines before prescriptions can be entered, and prompts requiring review of guidelines before a subsequent action can be taken in the record.		<p>and/or overdose, and helping to address the opioid epidemic.</p> <p><u>Validation Documentation:</u> Evidence of eligible clinicians utilizing the CDC Clinical Practice Guideline for Prescribing Opioids for Pain via CDS. Include all of the following elements:</p> <p>1) CDC Clinical Practice Guideline for Prescribing Opioids for Pain via CDS within eligible clinicians' workflow – Evidence that the CDC Clinical Practice Guideline for Prescribing Opioids for Pain is available to eligible clinician(s) via CDS, and that the guideline is incorporated into eligible clinicians' workflow. May include: electronic health record-based prescribing prompts, chronic pain order sets with opiate prescribing based on CDC Guidelines, or prompts requiring review of guidelines before a subsequent action can be taken in the record; AND</p> <p>2) Use of Guideline in CDS – Documentation of use of CDC guideline during patient care during the 90 day or year-long attestation period.</p> <p><u>Information:</u> CDC Guideline: https://www.cdc.gov/drugoverdose/prescribing/guideline.html; please note that this guideline was updated in November 2022. This guideline/CDS may be</p>	

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					updated periodically, and the most recent available guideline/CDS should be referred to/used in completing this activity.	
IA_PSPA_33	Patient Safety & Practice Assessment	Application of CDC's Training for Healthcare Providers on Lyme Disease	Apply the Centers for Disease Control and Prevention's (CDC) Training for Healthcare Providers on Lyme Disease using clinical decision support (CDS). CDS for Lyme disease should be built directly into the clinician workflow and support decision making for a specific patient at the point of care. Specific examples of how the guideline could be incorporated into a CDS workflow include but are not limited to: electronic health record (EHR) based prescribing prompts, order sets that require review of guidelines before prescriptions can be entered, and prompts requiring review of guidelines before a subsequent action can be taken in the record.	Medium	<p>Objective: Improve health outcomes for patients with Lyme disease by leveraging clinical decision support (CDS) and training tools.</p> <p>Validation Documentation: Evidence of eligible clinicians utilizing the Centers for Disease Control and Prevention's (CDC's) Training for Healthcare Providers on Lyme Disease via CDS. Include the following element:</p> <p>1) CDC Training for Healthcare Providers on Lyme Disease via CDS within eligible clinicians' workflow – Evidence that guidance from the CDC's training is available to eligible clinician(s) via CDS, and that guidance from the training is incorporated into eligible clinicians' workflow. May include: electronic health record-based prescribing prompts and/or Lyme Disease specific order sets, order sets that require review of training guidance, and prompts requiring review of guidelines before a subsequent action can be taken.</p> <p>Information: Agency for Healthcare Research and Quality's resources on CDS: https://cds.ahrq.gov/</p>	2022

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IA_AHE_1	Achieving Health Equity	Enhance Engagement of Medicaid and Other Underserved Populations	To improve responsiveness of care for Medicaid and other underserved patients: use time-to-treat data (i.e., data measuring the time between clinician identifying a need for an appointment and the patient having a scheduled appointment) to identify patterns by which care or engagement with Medicaid patients or other groups of underserved patients has not achieved standard practice guidelines; and with this information, create, implement, and monitor an approach for improvement. This approach may include screening for patient barriers to treatment, especially transportation barriers, and providing resources to improve engagement (e.g., state Medicaid non-emergency medical transportation benefit).	High	<p><u>Objective:</u> Ensure timely treatment of patients from underserved populations, to help them achieve improved health outcomes.</p> <p><u>Validation Documentation:</u> Evidence of eligible clinicians tracking and improving timeliness of care delivered to patients from underserved populations, including those with Medicaid, through analysis and intervention. Include both of the following elements:</p> <p>1) Analysis of time-to-treat data – Report documenting analysis of trends and inequities in time-to-treat data, disaggregated by beneficiary type (to compare those with and without Medicaid benefits) and by other patient demographics such as race/ethnicity, disability status, sexual orientation, sex, gender identity, or geography. Report should include possible explanations for the trends and inequities identified; AND</p> <p>2) Implementation Plan and Results – Documentation of plans for activities to address inadequacies in time-to-treat performance, and the outcomes of those activities. Activities may address barriers facing patients (e.g., lack of access to affordable transportation) or barriers presented by the eligible clinician (e.g., appointment availability does not align with needs of those who lack sick leave).</p>	2017

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
					<p><u>Example(s)</u>: An urban outpatient center is interested in assessing what inequities might exist in their current practice related to access to timely care. First, they analyze time-to-treat data, and look at differences by race/ethnicity, sex, zip code, and beneficiary type. They notice that patients with both Medicare and Medicaid benefits are most likely to miss or arrive late to appointments. They also notice that these patients are located in urban zip codes that have insufficiently accessible public transportation options to the outpatient center. To support these patients, the outpatient center researches Medicaid benefits related to transportation benefits in their state, and builds in EHR prompts for eligible clinicians to provide information about those benefits to all patients with Medicaid and Medicare. The center also institutes a call system that provides the information to Medicaid beneficiaries one week before their scheduled appointment. After several months of implementation, the outpatient center repeats their analysis of time-to-treat data and observes a small but noticeable improvement in timeliness of care for patients with Medicare and Medicaid services.</p> <p><u>Information</u>: The standardized screening for</p>	

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					transportation barriers, adopted by Centers for Medicare & Medicaid Services, is from the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) tool at: https://www.nachc.org/research-and-data/prapare/	
IA_AHE_3	Achieving Health Equity	Promote use of Patient-Reported Outcome Tools	Demonstrate performance of activities for employing patient-reported outcome (PRO) tools and corresponding collection of PRO data such as the use of PHQ-2 or PHQ-9, PROMIS instruments, patient reported Wound-Quality of Life (QoL), patient reported Wound Outcome, and patient reported Nutritional Screening.	High	<p><u>Objective:</u> Make it possible to use Patient Reported Outcomes (PRO) data as part of routine care, thus increasing patient engagement and health outcomes for all populations.</p> <p><u>Validation Documentation:</u> Demonstrated performance of activities to promote use of PRO tools and corresponding collection of PRO data. Include both of the following elements:</p> <p>1) Promotion of PRO tools – Evidence that eligible clinicians are promoting use of PRO tools with their patients (e.g., documented notes in electronic health record, PRO materials); AND</p> <p>2) PRO data collection – Feedback reports demonstrating use of PRO tools and corresponding collection of PRO data</p> <p><u>Information:</u></p> <ul style="list-style-type: none"> • PRO Measurement Information System (PROMIS): https://www.healthmeasures.net/explore-measurement-systems/promis 	2017

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					<ul style="list-style-type: none"> • Patient Health Questionnaire (PHQ): https://www.phqscreeners.com 	
IA_AHE_5	Achieving Health Equity	MIPS Eligible Clinician Leadership in Clinical Trials or CBPR	Lead clinical trials, research alliances, or community-based participatory research (CBPR) that identify tools, research, or processes that focus on minimizing disparities in healthcare access, care quality, affordability, or outcomes. Research could include addressing health-related social needs like food insecurity, housing insecurity, transportation barriers, utility needs, and interpersonal safety.	Medium	<p><u>Objective:</u> Encourage clinicians to minimize disparities in healthcare access, care quality, affordability, or outcomes by contributing to new and improved tools, research, or processes, which may include addressing health-related social needs.</p> <p><u>Validation Documentation:</u> Evidence of leadership in clinical trials, research alliances, or community-based participatory research (CPBR), focused on minimizing disparities in healthcare access, care quality, affordability, or outcomes. Include the following element:</p> <p>1) Evidence of research leadership about disparities – Documentation of participation and leadership by eligible clinicians in clinical trials, research alliances, or CBPR focused on addressing disparities to improve healthcare access, care quality, affordability, or outcomes. This research may include developing evidence about the influence of health-related social needs on disparities in health outcomes, and effective strategies for addressing HRSN.</p> <p><u>Example(s)/Information:</u></p> <ul style="list-style-type: none"> • Examples of evidence of participation in research on 	2018

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
					<p>disparities:</p> <ul style="list-style-type: none"> o Documentation that describes the intended or actual aims and/or intended outcomes of research o Tools developed as part of research activity that identify or help address disparities o Summary of findings, research results <p>• Background on identifying and addressing health-related social needs at primary care settings: https://www.ahrq.gov/sites/default/files/wysiwyg/evidence/now/tools-and-materials/social-needs-tool.pdf</p>	
IA_AHE_6	Achieving Health Equity	Provide Education Opportunities for New Clinicians	MIPS eligible clinicians acting as a preceptor for clinicians-in-training (such as medical residents/fellows, medical students, physician assistants, nurse practitioners, or clinical nurse specialists) and accepting such clinicians for clinical rotations in community practices in small, underserved, or rural areas.	High	<p><u>Objectives:</u> Provide clinicians-in-training with diverse experiences, allowing them to gain deep understanding of the challenges facing eligible clinicians and patients in small practices or in underserved or rural areas.</p> <p><u>Validation Documentation:</u> Evidence of participation as a preceptor for clinicians-in-training and accepting clinical rotations in community practices in small underserved or rural areas. Include all of the following elements:</p> <p>1) Proof of preceptor role – Documentation of participation as a preceptor for eligible clinicians-in-training (e.g., contract or communications with an academic-based health care organization). Any eligible clinician can serve as a preceptor; AND</p>	2018

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
					<p>2) Specific clinical rotations – Evidence of clinical rotation assignments in community practices in small, underserved, or rural areas. The 2019 CMS Final Rule defines small, underserved, or rural areas by ZIP codes designated as rural, using the most recent Health Resources and Services Administration (HRSA) Area Health Resource File data set.</p> <p><u>Information:</u> To confirm eligibility prior to attestation, CMS recommends that practices consult the HRSA Area Health Resource File: https://data.hrsa.gov/tools/shortage-area/by-address.</p> <p><u>Note:</u></p> <ul style="list-style-type: none"> • New eligible clinician training conducted at a practice not deemed to be in an underserved area, or provided at a university or hospital, would not meet the eligibility criteria. • Eligible clinicians who are not located in an underserved area and treat patients who come to the practice from underserved areas do not meet the intent of this activity. • Teaching at a hospital or university does not meet the intent of this activity. 	
IA_AHE_7	Achieving Health Equity	Comprehensive Eye Exams	To receive credit for this activity, MIPS eligible clinicians must	Medium	<p><u>Objectives:</u> Improve eye health of underserved and/or high-risk populations, and empower patients in these</p>	2019

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			<p>promote the importance of a comprehensive eye exam, which may be accomplished by any one or more of the following:</p> <ul style="list-style-type: none"> • providing literature, • facilitating a conversation about this topic using resources such as the “Think About Your Eyes” campaign, • referring patients to resources providing no-cost eye exams, such as the American Academy of Ophthalmology’s EyeCare America and the American Optometric Association’s VISION USA, or • promoting access to vision rehabilitation services as appropriate for individuals with chronic vision impairment. <p>This activity is intended for:</p> <ul style="list-style-type: none"> • Non-ophthalmologists / optometrists who refer patients to an ophthalmologist/optometrist; • Ophthalmologists/optometrists caring for underserved patients at 		<p>populations to become more educated consumers of eye care.</p> <p><u>Validation Documentation:</u> Evidence that eligible clinicians help underserved and/or high-risk populations understand the importance of their eye health and provide support to access comprehensive eye exams. Include all of the following elements:</p> <p>1) Proof of eligible clinician/group type – Evidence that the attesting eligible clinicians are either: a) providing literature and/or resources on the topic of comprehensive eye exam importance; a) non-ophthalmologists or optometrist who refer patients to an ophthalmologist/optometrist; b) ophthalmologists/optometrist caring for underserved patients at no cost; or c) eligible clinicians; AND</p> <p>2) Promotion of comprehensive eye exam – Documentation that literature and/or conversation about the importance of comprehensive eye exams were provided to targeted underserved and/or high-risk populations (e.g., visit note made in medical record; copy of literature provided); AND</p> <p>3) Referrals to no-cost eye exams – Documentation of patient referrals made to resources providing no-cost eye exams (e.g., American Academy of Ophthalmology’s EyeCare America, American</p>	

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
			<p>no cost; or</p> <ul style="list-style-type: none"> Any clinician providing literature and/or resources on this topic. <p>This activity must be targeted at underserved and/or high-risk populations that would benefit from engagement regarding their eye health with the aim of improving their access to comprehensive eye exams or vision rehabilitation services.</p>		Optometric Association's VISION USA) for targeted underserved and/or high-risk populations.	
IA_AHE_8	Achieving Health Equity	Create and Implement an Anti-Racism Plan	<p>Create and implement an anti-racism plan using the CMS Disparities Impact Statement or other anti-racism planning tools. The plan should include a clinic-wide review of existing tools and policies, such as value statements or clinical practice guidelines, to ensure that they include and are aligned with a commitment to anti-racism and an understanding of race as a political and social construct, not a physiological one.</p>	High	<p><u>Objective:</u> Begin to address inequities in health outcomes by creating and implementing an anti-racism plan.</p> <p><u>Validation Documentation:</u> Evidence of a practice-wide review and implementation of an anti-racism plan. Please note that, although the CMS Disparities Statement does not mention racism, it can be effectively used to facilitate the completion of the requirements of this activity. Include all of the following elements:</p> <ol style="list-style-type: none"> 1) Review – Documentation of a practice-wide review of existing tools and policies; AND 2) Assessment memo – Completion of an assessment 	2022

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			The plan should also identify ways in which issues and gaps identified in the review can be addressed and should include target goals and milestones for addressing prioritized issues and gaps. This may also include an assessment and drafting of an organization's plan to prevent and address racism and/or improve language access and accessibility to ensure services are accessible and understandable for those seeking care. The MIPS eligible clinician or practice can also consider including in their plan ongoing training on anti-racism and/or other processes to support identifying explicit and implicit biases in patient care and addressing historic health inequities experienced by people of color. More information about elements of the CMS Disparities Impact Statement is detailed in the template and action plan document at		<p>memo summarizing the results of the above review; AND</p> <p>3) Anti-Racism Plan –A new or updated anti-racism plan, which includes actions, intended outcomes, and timeline for completion for the eligible clinician's practice; this plan must identify ways in which issues and gaps identified in the review can be addressed and should include target goals and milestones, and the eligible clinician or practice should also consider including training on anti-racism to support identifying explicit and implicit biases in patient care and addressing historic health inequities experienced by people of color; AND</p> <p>4) Plan Implementation – Report with results from implementing the new or updated anti-racism plan.</p> <p><u>Example(s)</u>: A practice-wide review indicated that existing website and human-resources documents do not mention a commitment to anti-racism or an awareness of racism in medicine, and that, in a decision aid used in the practice, heart failure risk is estimated lower for individuals socially identified as Black than for patients socially identified as White, potentially making Black patients less likely to seek and/or receive needed care. The practice updated its website and human-resources materials to reflect its</p>	

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			https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Disparities-Impact-Statement-508-rev102018.pdf .		<p>commitment to anti-racism, and stopped using the heart failure risk decision aid that was biased against patients identified as Black, as part of a comprehensive anti-racism plan the practice developed and implemented.</p> <p><u>Information:</u></p> <ul style="list-style-type: none"> • CMS (healthequityTA@cms.hhs.gov) offers Health Equity technical assistance to organizations that would like support improving equity, including those who are using the Disparities Impact Statement: https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Disparities-Impact-Statement-508-rev102018.pdf • This 2018 article by Camara Phyllis Jones that details launching a National Campaign Against Racism with three tasks: 1) naming racism; 2) asking “how is racism operating here?” and 3) organizing and strategizing to act and an Anti-Racism Collaborative. “Toward the science and practice of anti-racism: Launching a national campaign against racism”: www.doi.org/10.18865/ed.28.S1.231 • A 2021 study by Hassen et. al. describes a scoping review conducted to identify existing anti-racism interventions in healthcare settings and synthesize the key findings, challenges and unintended consequences 	

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					<p>of this work. "Implementing Anti-Racism Interventions in Healthcare Settings: A Scoping Review": https://www.mdpi.com/1660-4601/18/6/2993/htm</p> <ul style="list-style-type: none"> • A 2020 Health Affairs article by Olayiwola et. al. describes the process of making anti-racism a core value in health care and the four pillars of an anti-racist action plan. "Making Anti-Racism A Core Value In Academic Medicine": https://www.healthaffairs.org/doi/10.1377/hblog20200820.931674/full/ • A 2020 Health Affairs article by Legha describes the five core components to an anti-racist approach to clinical care. "Getting Our Knees Off Black People's Necks: An Anti-Racist Approach to Medical Care": https://www.healthaffairs.org/doi/10.1377/hblog20201029.167296/full/ • University of San Francisco Gleeson Library's anti-racism resources list for health sciences. "Anti-Racism and Healthcare Research Guide": https://guides.usfca.edu/anti-racism-healthcare 	
IA_AHE_9	Achieving Health Equity	Implement Food Insecurity and Nutrition Risk Identification and Treatment Protocols	Create or improve, and then implement, protocols for identifying and providing appropriate support to: a) patients with or at risk for food insecurity, and b) patients with or at risk for	Medium	<p><u>Objective:</u> Reduce food insecurity and improve nutritional outcomes for at-risk patients.</p> <p><u>Validation Documentation:</u> Evidence of screening for food insecurity and malnutrition risk and implementing protocols to support patients who are</p>	2022

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			<p>poor nutritional status. (Poor nutritional status is sometimes referred to as clinical malnutrition or undernutrition and applies to people who are overweight and underweight.) Actions to implement this improvement activity may include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Use Malnutrition Quality Improvement Initiative (MQii) or other quality improvement resources and standardized screening tools to assess and improve current food insecurity and nutritional screening and care practices. • Update and use clinical decision support tools within the MIPS eligible clinician's electronic medical record to align with the new food insecurity and nutrition risk protocols. • Update and apply requirements for staff training on food security and nutrition. 		<p>identified as at risk. Include both of the following:</p> <p>1) Protocols for identifying at-risk patients created or improved – Documentation of screening tools—preferably standardized tools that have been tested in underserved communities—applied within clinician workflow and information stored within health information systems; AND</p> <p>2) Implementation Plan and Results – Documentation of the plan to advance support to patients who have been identified as having the greatest risk for food insecurity and/or malnutrition, with specific rationale for the interventions selected and documentation of the results achieved.</p> <p>Example: A practice selects and adapts two standardized tools for screening patients for food insecurity and malnutrition into their electronic health record (EHR) system and begins screening all new patients and existing patients each year. The Quality Improvement team at the practice also establishes a new process whereby, during the visit when the screening occurs, the practice provides those identified as having risk of food insecurity or malnutrition with a) information and counseling about the national Supplemental Nutrition Assistance Program (SNAP) enrollment and b) an information sheet with referrals to food pantries and other</p>	

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			<ul style="list-style-type: none"> • Update and provide resources and referral lists, and/or engage with community partners to facilitate referrals for patients who are identified as at risk for food insecurity or poor nutritional status during screening. <p>Activities must be focused on patients at greatest risk for food insecurity and/or malnutrition—for example patients with low income who live in areas with limited access to affordable fresh food, or who are isolated or have limited mobility.</p>		<p>community resources in the area. The Quality Improvement group also establishes protocols for calling patients who received counselling and information 3 weeks after their visit to follow-up. At the end of the year, the Quality Improvement group documents within their EHR an increase in SNAP enrollment among their patient population.</p> <p><u>Information:</u></p> <ul style="list-style-type: none"> • The following screening tools are tested and standardized, and include screening questions for food insecurity: <ul style="list-style-type: none"> o Accountable Health Communities screening tool at: https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf o Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) tool at: https://www.nachc.org/research-and-data/prapare/ o Health Leads' Screening Toolkit at: https://healthleadsusa.org/resources/the-health-leads-screening-toolkit/ • The following screening tools for nutrition/malnutrition are tested and recommended, though there are many other tools that would be 	

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					<p>appropriate to use:</p> <ul style="list-style-type: none"> o Malnutrition Screening Tool (MST) o Subjective Global Assessment (SGA) o Mini Nutritional Assessment (MNA) o Malnutrition Universal Screening Tool (MUST) <p>• Search for other tools using Kaiser Permanente's screening tool database: https://sdh-tools-review.kp.washingtonresearch.org/find-tools/submit/715</p> <p>• Agency for Healthcare Research and Quality's resources on CDS: https://cds.ahrq.gov/</p> <p>• Search for local Aging and Disability Resource Centers and Area Agencies of Aging to find out how they can help connect Medicare beneficiaries to funded home delivered meals, congregate meals and other nutrition services provided through the Older Americans Act as well as other state and local food programs (assistance applying for SNAP benefits, connection to local food pantries etc.).</p>	
IA_AHE_10	Achieving Health Equity	Adopt Certified Health Information Technology for Security Tags for Electronic	Use security labeling services available in certified Health Information Technology (IT) for electronic health record (EHR) data to facilitate data segmentation. Certification criteria for security tags may be found in the ONC	Medium	<p><u>Objective:</u> To promote the adoption of technology certified to the Security tags-summary of care send and Security tags-summary of care receive criteria at 45 CFR 170.315(b)(7) and (b)(8) in the ONC Health IT Certification Program.</p> <p><u>Validation Documentation:</u> Evidence of eligible</p>	2023

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		Health Record Data	Health IT Certification Program at 45 CFR 170.315(b)(7) and (b)(8).		<p>clinician's practice working with their EHR vendor to implement technology meeting the security tags criteria at 45 CFR 170.315 (b)(7) and (b)(8) in practice systems and clinic workflows. Documentation can include the following elements:</p> <p>1) Screen shots of the EHR including security tag technology meeting the certification criteria; OR</p> <p>2) EHR-vendor documentation of the addition of security tagging certified health IT in the practice's systems; AND/OR</p> <p>3) Practice policies & procedures manual and/or training materials related to security tagging technology meeting the certified health IT criteria in the EHR; AND/OR</p> <p>4) Submission of a CMS EHR Certification ID for the certified health IT used by the eligible clinician which includes health IT certified to 45 CFR 170.315(b)(7) and (b)(8).</p> <p><u>Information:</u> HealthIT.gov. (n.d.). "Security tags - summary of care - send" criterion (45 CFR 170.315(b)(7)), https://www.healthit.gov/test-method/data-segmentation-privacy-send; "Security tags - summary of care - receive" criterion (45 CFR 170.315(b)(8)), https://www.healthit.gov/test-method/data-segmentation-privacy-receive.</p>	

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IA_AHE_11	Achieving Health Equity	Create and Implement a Plan to Improve Care for Lesbian, Gay, Bisexual, Transgender, and Queer Patients	Create and implement a plan to improve care for lesbian, gay, bisexual, transgender, and queer (LGBTQ+) patients by understanding and addressing health disparities for this population. The plan may include an analysis of sexual orientation and gender identity (SO/GI) data to identify disparities in care for LGBTQ+ patients. Actions to implement this activity may also include identifying focused goals for addressing disparities in care, collecting and using patients' pronouns and chosen names, training clinicians and staff on SO/GI terminology (including as supported by certified health IT and the Office of the National Coordinator for Health Information Technology US Core Data for Interoperability [USCDI]), identifying risk factors or behaviors specific to LGBTQ+ individuals, communicating SO/GI data security	High	<p><u>Objective:</u> Begin to address disparities in health care and health outcomes for LGBTQ+ people by creating and implementing a plan to improve care for lesbian, gay, bisexual, transgender, and queer patients.</p> <p><u>Validation documentation:</u> Evidence of a practice-wide review and implementation of a plan to improve care for LGBTQ+ patients.</p> <p>1) Review - Documentation of a practice-wide review of existing tools and policies; AND</p> <p>2) Assessment memo - Completion of an assessment memo summarizing the results of the above review; AND</p> <p>3) Plan to Improve Care for LGBTQ+ patients - A new or updated plan, which includes actions, intended outcomes, and timeline for completion for the eligible clinician's practice; this plan must identify ways in which issues and gaps identified in the review can be addressed and should include target goals and milestones, and the eligible clinician or practice should also consider including training on sexual orientation and gender identity; AND</p> <p>4) Plan Implementation - Report with results from implementing the new or updated plan for improving care for LGBTQ+ patients.</p>	2023

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			and privacy practices with patients, and/or utilizing anatomical inventories when documenting patient health histories.		<p>Example(s): A practice-wide review indicated that existing website and human-resources documents do not mention a commitment to inclusion of LGBTQ+ people, and that electronic medical records data on sexual orientation and gender identity are frequently incomplete. The practice updated its website and human-resources materials to reflect its commitment to caring for LGBTQ+ patients, and trained clinicians on best practices for gathering and documenting sexual orientation and gender identity data in health records.</p> <p><u>Information:</u></p> <ul style="list-style-type: none"> • This Institute of Medicine report assesses the state of science on the health status of LGBT populations in three life stages – childhood and adolescence, early/middle adulthood, and later adulthood: The Health of Lesbian, Gay, Bisexual and Transgender People: Building a Foundation for Better Understanding. (https://nap.nationalacademies.org/catalog/13128/the-health-of-lesbian-gay-bisexual-and-transgender-people-building) • CMS offers a one-hour web-based training course for health care providers and staff who are responsible for collecting Medicare patient data from LFBTQ people: Improving Health Care Quality for LGBTQ People. 	

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					<p>(https://www.cms.gov/Outreach-and-Education/MLN/WBT/MLN3390633-OMH-LGBTQ/OMHLGBTQ/sogi/index.html)</p> <ul style="list-style-type: none"> • This 2019 article by Chris Grasso et. al. presents recommendations for planning and implementing high-quality sexual orientation and gender identity data collection in health care practices: Planning and implementing sexual orientation and gender identity data collection electronic health records. Journal of the American of Medical Informatics Association 2019 Jan 1;26(1)66-70. <p>(https://pubmed.ncbi.nlm.nih.gov/30445621/)</p> <ul style="list-style-type: none"> • This training manual from the National LGBT Health Education Center provides information for clinicians and other staff working in health care to help them understand transgender and gender-diverse people and their health needs, and offers tips and strategies for communication with and about transgender and gender-diverse individuals: Affirmative Services for Transgender and Gender-Diverse People. <p>(https://www.lgbtqiahealtheducation.org/wp-content/uploads/2020/03/TFIE-40_Best-Practices-for-Frontline-Health-Care-Staff-Publication_web_final.pdf)</p>	

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IA_AHE_12	Achieving Health Equity	Practice Improvements that Engage Community Resources to Address Drivers of Health	<p>Select and screen for drivers of health that are relevant for the eligible clinician's population using evidence-based tools. If possible, use a screening tool that is health IT-enabled and includes standards-based, coded questions/fields for the capture of data. After screening, address identified drivers of health through at least one of the following:</p> <ul style="list-style-type: none"> • Develop and maintain formal relationships with community-based organizations to strengthen the community service referral process, implementing closed-loop referrals where feasible; or • Work with community partners to provide and/or update a community resource guide for to patients who are found to have and/or be at risk in one or more areas of drivers of health; or • Record findings of screening and follow up within the electronic health record (EHR); identify 	High	<p><u>Objective:</u> Improve the screening and documentation of drivers of health needs using evidence-based tools.</p> <p><u>Validation Documentation:</u> Evidence of screening for the drivers of health, specified by the MIPS eligible clinician for this activity, and documentation of actions taken to address any identified needs. In addition to the drivers of health listed in the activity description, drivers of health prioritized by the MIPS eligible clinician may include others (e.g., transportation accessibility; interpersonal safety; legal challenges; and environmental exposures). Include the first element and one of the following elements:</p> <p>1) Use of a validated patient drivers of health screening tool – Copy of implemented screening tool (e.g., completed survey or completed verbal assessment) used to identify patients with one or more specified. If feasible, the screening tool should be electronically enabled and include standards-based, coded question(s)/field(s) for the capture of data; AND</p> <p>2) Provision of community resource guides – Medical record note/field indicating provision of a guide to community resources to meet specified drivers of health needs to patients with those identified needs. The MIPS eligible clinician should update this guide, or obtain an updated guide from community partners, at</p>	2017

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			<p>screened patients with one or more needs associated with drivers of health and implement approaches to better serve their holistic needs through meaningful linkages to community resources.</p> <p>Drivers of health (also referred to as social determinants of health [SDOH] or health-related social needs [HSRN]) prioritized by the practice might include, but are not limited to, the following: food security; housing stability; transportation accessibility; interpersonal safety; legal challenges; and environmental exposures.</p>		<p>least once during the performance year; OR</p> <p>3) Community referrals – Evidence (e.g., email, Memorandum of Understanding, meeting minutes, data sharing agreement) demonstrating formal relationships with established referral processes between the MIPS eligible clinician and one or more community-based organizations; OR</p> <p>4) Electronic Health Record (EHR)/registry data analysis – Record of analysis of EHR or registry data that identifies patients with an need related to drivers of health and documents follow-up with identified patient(s).</p> <p><u>Information:</u></p> <ul style="list-style-type: none"> • Drivers of health Screening Tools that meet the recommended criteria for this activity include: CMS's Accountable Health Communities screening tool: https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf; National Association of Community Health Centers' PRAPARE assessment: https://www.nachc.org/wp-content/uploads/2020/04/PRAPARE-One-Pager-9-2-16-with-logo-and-trademark.pdf; Health Lead's Screening Tool: https://healthleadsusa.org/resources/the-health-leads-screening-toolkit/ 	

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					<ul style="list-style-type: none"> • Other tools in Kaiser Permanente's screening tool database: https://sdh-tools-review.kp.washingtonresearch.org/find-tools/submit/715. • Map screening findings to Z-Codes within EHR systems: https://www.cms.gov/files/document/zcodes-infographic.pdf • Background on drivers of health/health-related social needs in primary care settings: https://www.ahrq.gov/sites/default/files/wysiwyg/evidence/now/tools-and-materials/social-needs-tool.pdf. 	
IA_ERP_1	Emergency Response & Preparedness	Participation on Disaster Medical Assistance Team, registered for 6 months.	Participation in Disaster Medical Assistance Teams, or Community Emergency Responder Teams. Activities that simply involve registration are not sufficient. MIPS eligible clinicians and MIPS eligible clinician groups must be registered for a minimum of 6 months as a volunteer for disaster or emergency response.	Medium	<p><u>Objective:</u> Provide sustained support to communities facing the impact of disasters, filling immediate needs, and contributing to a faster, better recovery.</p> <p><u>Validation Documentation:</u> Evidence of participation in Disaster Medical Assistance Team or Community Emergency Responder Team for at least 6 months as a volunteer. Include the following element:</p> <p>1) Details and confirmation of participation – Documentation of participation in Disaster Medical Assistance or Community Emergency Responder Teams for at least 6 months including registration and active participation (e.g., attendance at training, on-site participation).</p>	2017

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IA_ERP_2	Emergency Response & Preparedness	Participation in a 60-day or greater effort to support domestic or international humanitarian needs.	Participation in domestic or international humanitarian volunteer work. Activities that simply involve registration are not sufficient. MIPS eligible clinicians and groups attest to domestic or international humanitarian volunteer work for a period of a continuous 60 days or greater.	High	<p><u>Objective:</u> Provide sustained support to communities across the globe that need humanitarian volunteer support, thus helping to alleviate suffering, save lives, and maintain human dignity.</p> <p><u>Validation Documentation:</u> Evidence of participation in domestic or international humanitarian volunteer work for at least a continuous 60 day duration. Include the following element:</p> <p>1) Details and confirmation of participation – Documentation of participation in domestic or international humanitarian volunteer work for at least a continuous 60 day duration including registration and active participation (e.g., identification of location of volunteer work, timeframe, and confirmation from humanitarian organization).</p>	2017
IA_ERP_3	Emergency Response & Preparedness	COVID-19 Clinical Data Reporting with or without Clinical Trial	To receive credit for this improvement activity, a MIPS eligible clinician or group must: (1) participate in a COVID-19 clinical trial utilizing a drug or biological product to treat a patient with a COVID-19 infection and report their findings through a clinical data repository or clinical data registry for the duration of their study; or	High	<p><u>Objective:</u> Contribute to the development of clinically proven treatments for COVID-19.</p> <p><u>Validation Documentation:</u> Evidence of participation in the COVID-19 clinical trial. Include both of the following elements:</p> <p>1) Clinical trial details – Details to verify participation in an acceptable COVID-19 clinical trial. The type of clinical trial could include designs ranging from the traditional double-blinded placebo-controlled trial to</p>	2020

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			<p>(2) participate in the care of patients diagnosed with COVID-19 and simultaneously submit relevant clinical data to a clinical data registry for ongoing or future COVID-19 research. Data would be submitted to the extent permitted by applicable privacy and security laws. Examples of COVID-19 clinical trials may be found on the U.S. National Library of Medicine website at https://clinicaltrials.gov/ct2/results?cond=COVID-19. In addition, examples of COVID-19 clinical data registries may be found on the National Institute of Health website at https://search.nih.gov/search?utf8=%E2%9C%93&affiliate=nih&query=COVID19+registries&commit=Search.</p> <p>For purposes of this improvement activity, clinical data registries must meet the following requirements:</p> <p>(1) the receiving entity must</p>		<p>an adaptive design or pragmatic design that flexes to workflow and clinical practice context. It may be conducted in large organized clinical trials led by academic medical centers or healthcare systems. In addition, we intend for this activity to be applicable to eligible clinicians who are reporting their COVID-19 related patient data to a clinical data repository, such as Oracle's COVID-19 Therapeutic Learning System (https://covid19.oracle.com/); AND</p> <p>2) Clinical data submission – Evidence of submission of clinical data to the clinical data repository or registry supporting the COVID-19 clinical trial (e.g., screenshot from the participating clinical data repository or clinical data registry).</p> <p><u>Example(s)</u>: Data registries may include:</p> <ul style="list-style-type: none"> • Healthcare Worker Exposure Response & Outcomes (HERO) Registry: https://protect2.fireeye.com/url?k=b5fdaaa2-e9a9b3de-b5fd9b9d-0cc47adc5fa2-990d9a8e6607466a&u=http://www.heroesresearch.org/ • American Heart Association (AHA) COVID-19 cardiovascular disease (CVD) registry: https://www.heart.org/en/professional/quality-improvement/covid-19-cvd-registry 	

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			declare that they are ready to accept data as a clinical registry; and (2) be using the data to improve population health outcomes. Most public health agencies and clinical data registries declare readiness to accept data from clinicians via a public online posting. Clinical data registries should make publically available specific information on what data the registry gathers, technical requirements or specifications for how the registry can receive the data, and how the registry may use, re-use, or disclose individually identifiable data it receives. For purposes of credit toward this improvement activity, any data should be sent to the clinical data registry in a structured format, which the registry is capable of receiving. A MIPS-eligible clinician may submit the data using any standard or format that is supported by the clinician's health		<u>Information:</u> For more information on the COVID-19 clinical trials we refer readers to the U.S. National Library of Medicine website at https://clinicaltrials.gov/ct2/results?cond=COVID-19 .	

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			IT systems, including but not limited to, certified functions within those systems. Such methods may include, but are not limited to, a secure upload function on a web portal, or submission via an intermediary, such as a health information exchange. To ensure interoperability and versatility of the data submitted, any electronic data should be submitted to the clinical data registry using appropriate vocabulary standards for the specific data elements, such as those identified in the United States Core Data for Interoperability (USCDI) standard adopted in 45 CFR 170.213.			
IA_ERP_4	Emergency Response & Preparedness	Implementation of a Personal Protective Equipment (PPE) Plan	<p>Implement a plan to acquire, store, maintain, and replenish supplies of personal protective equipment (PPE) for all clinicians or other staff who are in physical proximity to patients.</p> <p>In accordance with guidance from</p>	Medium	<p><u>Objective:</u> Ensure the safety of patients and staff by maintaining a sufficient supply of personally protective equipment (PPE) for all clinicians and other health workers.</p> <p><u>Validation Documentation:</u> Documentation of a PPE plan that describes PPE controls and/or a control plan. Include all of the following elements:</p>	2022

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			<p>the Centers for Disease Control and Prevention (CDC) the PPE plan should address:</p> <ul style="list-style-type: none"> • Conventional capacity: PPE controls that should be implemented in general infection prevention and control plans in healthcare settings, including training in proper PPE use. • Contingency capacity: actions that may be used temporarily during periods of expected PPE shortages. • Crisis capacity: strategies that may need to be considered during periods of known PPE shortages. The PPE plan should address all of the following types of PPE: <ul style="list-style-type: none"> • Standard precautions (e.g., hand hygiene, prevention of needle-stick or sharps injuries, safe waste management, cleaning and disinfection of the environment) • Eye protection • Gowns (including coveralls or aprons) 		<p>1) Plans for conventional, contingency and crisis capacity situations; AND</p> <p>2) Documentation of training – (e.g., curriculum, materials that will be conducted for staff in the use of PPE); AND</p> <p>3) Documentation of procurement or existing inventory – This should include all of the following types of PPE:</p> <ul style="list-style-type: none"> • Standard precautions (e.g., hand hygiene, prevention of needle-stick or sharps injuries, safe waste management, cleaning and disinfection of the environment) • Eye protection • Gowns (including coveralls or aprons) • Gloves • Facemasks • Respirators (including N95 respirators) 	

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
			<ul style="list-style-type: none"> • Gloves • Facemasks • Respirators (including N95 respirators) 			
IA_ERP_5	Emergency Response & Preparedness	Implementation of a Laboratory Preparedness Plan	<p>Develop, implement, update, and maintain a preparedness plan for a laboratory intended to support continued or expanded patient care during COVID-19 or another public health emergency. The plan should address how the laboratory would maintain or expand patient access to health care services to improve beneficiary health outcomes and reduce healthcare disparities.</p> <p>For laboratories without a preparedness plan, MIPS eligible clinicians would meet with stakeholders, record minutes, and document a preparedness plan, as needed. The laboratory must then implement the steps identified in the plan and maintain them.</p> <p>For laboratories with existing preparedness plans, MIPS eligible</p>	Medium	<p><u>Objective:</u> Ensure preparedness and safety of staff working in laboratories providing patient care during COVID-19 or another public health emergency.</p> <p><u>Validation Documentation:</u> Documentation of an existing or in-progress laboratory preparedness plan. Include the following elements:</p> <p>1) Details on safety – Procedures and plans for maintaining safety, applicable to new/ongoing public health emergencies; AND</p> <p>2) Details on implementation – Evidence of maintenance and implementation of this new or existing plan, which may include documentation of materials, results, etc. from a drill, training, checklist, assessment or debrief conducted.</p>	2022

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
			<p>clinicians should review, revise, or update the plan as necessary to meet the needs of the current PHE, implement new procedures, and maintain the plan.</p> <p>Maintenance of the plan in this activity could include additional hazard assessments, drills, training, and/or developing checklists to facilitate execution of the plan.</p> <p>Participation in debriefings to evaluate the effectiveness of plans are additional examples of engagement in this activity.</p>			
IA_ERP_6	Emergency Response & Preparedness	COVID-19 Vaccine Achievement for Practice Staff	Demonstrate that the MIPS eligible clinician's practice has maintained or achieved a rate of 100% of office staff staying up to date with COVID vaccines according to the Centers for Disease Control and Prevention (https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html). Please note that those who are determined to have a medical contraindication specified	Medium	<p><u>Objective:</u> Achieve or maintain 100% of practice staff up to date with COVID vaccines.</p> <p><u>Validation Documentation:</u> Evidence supporting that COVID-19 vaccinations are up to date for clinical and non-clinical office staff, according to current CDC guidelines. Include all of the following elements:</p> <p>1) Documentation approach – Standardized approach to documenting vaccination status for existing and new employees; AND</p> <p>2) Employee education – Materials emphasizing the importance of COVID-19 vaccination for all staff in a</p>	2023

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
			by CDC recommendations are excluded from this activity.		<p>health care setting; AND</p> <p>3) Documented process for vaccine administration – Written options for staff who require COVID-19 vaccines to receive vaccination at the practice or at other locations.</p> <p><u>Example(s)</u>: A practice-wide review indicated that some staff had not received the recommended COVID-19 vaccine doses. The practice educated staff on the importance of COVID-19 vaccination, and provided information on where no-cost vaccines could be obtained.</p> <p><u>Information</u>:</p> <ul style="list-style-type: none"> • The Centers for Disease Control and Prevention includes updated vaccine recommendations, including primary series and boosters, on its website: “Stay Up to Date with Your COVID-19 Vaccines”. (https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html#:~:text=CDC%20recommends%20COVID-19%20primary,-19%20vaccines%2C%20including%20boosters) • The Centers for Disease Control and Prevention developed educational materials for workplaces to support COVID-19 recommendations. Educational 	

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
					<p>materials about the importance of the COVID-19 vaccine and how the vaccine works are available as free print resources. (https://www.cdc.gov/coronavirus/2019-ncov/communication/print-resources.html?Sort=Date%3A%3Adesc&Audience=General%20Public%20%3E%20Employers%2C%20Business%20Owners%20%26%20Community%20Leaders&Topics=Vaccines&Content%20Type=Print%20resource)</p> <ul style="list-style-type: none"> • In this video, Dr. Arthur Caplan, head of the Division of Medical Ethics at NYU Grossman School of Medicine, talks about vaccine hesitancy among US health care workers and outlines the steps health care practices can take to boost vaccination rates among skeptical staff and support a healthy workforce. An audio-only file and a transcript are also available. (https://journalofethics.ama-assn.org/videocast/ethics-talk-covid-19-vaccine-hesitancy-health-care-workforce) 	
IA_BMH_1	Behavioral and Mental Health	Diabetes screening	Diabetes screening for people with schizophrenia or bipolar disease who are using antipsychotic medication.	Medium	<p><u>Objective:</u> Improve rates of screening for patients with schizophrenia or bipolar disorder, who have higher risk or higher prevalence of diabetes relative to the general population, thus increasing eligible clinicians' ability to detect and respond early to positive diagnoses, potentially reducing the burden and complications of the disease.</p>	2017

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
					<p><u>Validation Documentation:</u> Demonstration of diabetes screening for patients with schizophrenia or bipolar disease who are using antipsychotic medication. Include both of the following elements:</p> <p>1) Identification of patients – Evidence of regular identification of patients with schizophrenia or bipolar disease who are using antipsychotic medication and who should receive diabetes screening (e.g., report from the electronic health record [EHR], flag or note in the EHR or medical chart, registry, other population health management tracking report); AND</p> <p>2) Documented diabetes screenings – Percentage of patients identified in element “1)” (for example, annually) who receive a diabetes screening, with supporting documentation from EHR reports, medical charts, or claims.</p>	
IA_BMH_2	Behavioral and Mental Health	Tobacco use	Tobacco use: Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including tobacco use screening and cessation interventions (refer to NQF #0028) for patients with co-occurring conditions of behavioral	Medium	<p><u>Objective:</u> Help patients at high risk for tobacco dependence and with behavioral or mental conditions to avoid or end addiction to tobacco.</p> <p><u>Validation Documentation:</u> Demonstration of regular engagement in integrated prevention and treatment interventions including tobacco use screening and cessation interventions for patients with a diagnosis of behavioral or mental health disorders with risk factors</p>	2017

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
			or mental health and at risk factors for tobacco dependence.		for tobacco dependence. Include all of the following elements: 1) Identification of patients with behavioral or mental health conditions and tobacco dependence risk factors – Report from the electronic health record (EHR), qualified clinical data registry (QCDR), clinical registry, or other system demonstrating that the eligible clinician tracks patients with conditions of behavioral health or mental health with risk factors for tobacco dependence; AND 2) Evidence of screening – Report from EHR, QCDR, clinical registry, or documentation from medical charts showing regular practice of tobacco screening for patients with conditions of behavioral or mental health with risk factors for tobacco dependence; AND 3) Evidence of cessation interventions – Report from EHR, QCDR, clinical registry, or documentation from medical charts showing regular practice of tobacco cessation interventions for patients with behavioral or mental health disorders with risk factors for tobacco dependence.	
IA_BMH_4	Behavioral and Mental Health	Depression screening	Depression screening and follow-up plan: Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including	Medium	<u>Objective:</u> Improve the identification of depression among patients with behavioral or mental health conditions and sustain patient-centered support and treatment for those diagnosed with depression.	2017

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
			depression screening and follow-up plan (refer to NQF #0418) for patients with co-occurring conditions of behavioral or mental health conditions.		<p><u>Validation Documentation:</u> Demonstration of regular engagement in integrated prevention and treatment interventions including depression screening and follow-up plan for patients diagnosed with behavioral or mental health disorders. Include all of the following elements:</p> <p>1) Identification of patients with behavioral or mental health conditions and depression risk factors – Report from the electronic health record (EHR), qualified clinical data registry (QCDR), clinical registry, or other system demonstrating that the eligible clinician tracks patients with conditions of behavioral health or mental health and with risk factors for depression; AND</p> <p>2) Evidence of depression screening – Report from the electronic health record (EHR), qualified clinical data registry (QCDR), clinical registry, or documentation from medical charts showing regular practice for depression screening for patients with diagnosed behavioral or mental health disorders; AND</p> <p>3) Evidence of depression follow-up – Report from EHR, QCDR, clinical registry, or documentation from medical charts showing depression follow-up plan for patients with positive screen.</p>	

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
IA_BMH_5	Behavioral and Mental Health	MDD prevention and treatment interventions	Major depressive disorder: Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including suicide risk assessment (refer to NQF #0104) for mental health patients with co-occurring conditions of behavioral or mental health conditions.	Medium	<p><u>Objective:</u> Increase patient-centered support and treatment for patients with conditions of behavioral or mental health conditions to prevent severe depression and suicide.</p> <p><u>Validation Documentation:</u> Demonstration of regular engagement in prevention and treatment interventions including suicide risk assessment for mental health patients with conditions of behavioral or mental health. Include all of the following elements:</p> <p>1) Identification of patients with behavioral or mental health conditions and depression risk factors – Report from the electronic health record (EHR), qualified clinical data registry (QCDR), clinical registry or other system demonstrating that the eligible clinician tracks patients with conditions of behavioral health or mental health and with risk factors for depression; AND</p> <p>2) Evidence of screening – Report from the electronic health record (EHR), qualified clinical data registry (QCDR), clinical registry, or documentation from medical charts showing regular practice for screening, including suicide risk assessment for mental health patients with behavioral or mental health disorders; AND</p> <p>3) Evidence of prevention and treatment – Report</p>	2017

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
					from EHR, QCDR, clinical registry, or documentation from medical charts showing patients receiving prevention and/or treatment services based on screening results.	
IA_BMH_6	Behavioral and Mental Health	Implementation of co-location PCP and MH services	Integration facilitation and promotion of the colocation of mental health and substance use disorder services in primary and/or non-primary clinical care settings.	High	<p><u>Objective:</u> Integrate mental health and substance use disorder services with primary and/or non-primary clinical care through the co-location and co-promotion of these services.</p> <p><u>Validation Documentation:</u> Evidence of integrated mental health and substance use disorder services in primary and/or non-primary clinical care settings and promotion to patients. Include both of the following elements:</p> <p>1) Co-location of services – Documentation of integration and promotion of co-located mental health and substance use disorder services in primary and/or non-primary clinical care settings, (e.g., list of National Provider Identifiers [NPIs] for clinicians who participate as behavioral health specialists, mental health clinicians or primary care clinicians in co-located settings or patient claims showing mental health and substance use disorder services co-located in primary and/or non-primary clinical care settings); AND</p> <p>2) Promotion of co-located services – Evidence that</p>	2017

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
					co-located services are promoted or advertised to patients and regularly utilized in care (e.g., record of warm handoffs, promotion materials in waiting room, promotion of services in patient portal).	
IA_BMH_7	Behavioral and Mental Health	Implementation of Integrated Patient Centered Behavioral Health Model	<p>Offer integrated behavioral health services to support patients with behavioral health needs who also have conditions such as dementia or other poorly controlled chronic illnesses. The services could include one or more of the following:</p> <ul style="list-style-type: none"> • Use evidence-based treatment protocols and treatment to goal where appropriate; • Use evidence-based screening and case finding strategies to identify individuals at risk and in need of services; • Ensure regular communication and coordinated workflows between MIPS eligible clinicians in primary care and behavioral health; • Conduct regular case reviews for at-risk or unstable patients and those who are not responding to 	High	<p><u>Objective:</u> Support patients with behavioral health needs and poorly controlled chronic illnesses through integrated behavioral health services and the use of evidence-based tools or other initiatives.</p> <p><u>Validation Documentation:</u> Evidence of integrated behavioral health services to support patients with behavioral health needs and poorly controlled chronic conditions (may use certified electronic health records (EHR), qualified clinical data registry (QCDR), clinical registry, or medical records). Include at least one of the following elements:</p> <p>1) Use of evidence-based tools – Documented use of evidence-based tools (e.g., treatment protocols, screening tools); OR</p> <p>2) Communication between primary care and behavioral health – Documentation could include EHR note that shows that the patient saw a behavioral health professional who communicated with the eligible primary care clinician or practice team, a record of a referral by the eligible primary care clinician to a behavioral health specialist, or</p>	2017

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
			treatment; <ul style="list-style-type: none"> • Use of a registry or health information technology functionality to support active care management and outreach to patients in treatment; • Integrate behavioral health and medical care plans and facilitate integration through co-location of services when feasible; and/or • Participate in the National Partnership to Improve Dementia Care Initiative, which promotes a multidimensional approach that includes public reporting, state-based coalitions, research, training, and revised surveyor guidance. 		documentation of staffing or behavioral health co-located in the primary care practice; OR 3) Behavioral health integration in primary care – Documented integration of behavioral health services with primary care to support patients with behavioral health needs (e.g., dementia) and poorly controlled chronic conditions (e.g., hypertension, diabetes, chronic kidney disease); OR 4) Active care management and outreach – Use of a clinical registry or certified EHR to support active care management and outreach to patients receiving treatment; OR 5) Participation in a relevant program or initiative – Participation in a program or initiative with a multidimensional approach to support patients with behavioral health needs and poorly controlled chronic conditions (e.g., National Partnership to Improve Dementia Care in Nursing Homes).	
IA_BMH_8	Behavioral and Mental Health	Electronic Health Record Enhancements for BH data capture	Enhancements to an electronic health record to capture additional data on behavioral health (BH) populations and use that data for additional decision-making purposes (e.g., capture of additional BH data results in additional depression screening for	Medium	<u>Objective:</u> Continually improve the care provided to behavioral health populations through evidence-based interventions and the use of electronic health record technology (EHR). <u>Validation Documentation:</u> Documented use of EHR to capture data on behavioral health populations and use data to inform clinical decision-making. Include both of	2017

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
			at-risk patient not previously identified).		<p>the following elements:</p> <p>1) Screenshots of data capture – Screenshots from EHR or from other software/tools integrated with the EHR displaying behavioral health data capture (e.g., capture of additional behavioral health data results in additional depression screening for at risk patient not previously identified); AND</p> <p>2) Data reports – Reports showing how additional behavioral health data are captured and used for decision-making (e.g., dashboards, improvement plans).</p> <p><u>Example(s)</u>: An eligible clinician or practice expands data capture for behavioral health populations to include information on substance use, potential eating disorders, and social determinants of health. This eligible clinician or practice also ensures that all data on chronic medical conditions is being captured for these individuals. Through this improved data capture, the eligible clinician or practice identifies a subgroup of patients misusing substances and works to engage these patients in cognitive behavioral therapy.</p>	
IA_BMH_9	Behavioral and Mental Health	Unhealthy Alcohol Use for Patients with Co-occurring	Individual MIPS eligible clinicians or groups must regularly engage in integrated prevention and treatment interventions, including	High	<u>Objective</u> : Help patients better manage or overcome their alcohol and/or other substance abuse challenges through screenings and counseling.	2018

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
		Conditions of Mental Health and Substance Abuse and Ambulatory Care Patients	screening and brief counseling (for example: NQF #2152) for patients with co-occurring conditions of mental health and substance abuse. MIPS eligible clinicians would attest that 60 percent for the CY 2018 Quality Payment Program performance period, and 75 percent beginning in the 2019 performance period, of their ambulatory care patients are screened for unhealthy alcohol use.		<p><u>Validation Documentation:</u> Evidence of regular integrated prevention and treatment interventions with documented screening and brief counseling for patients with diagnosed coexistence of a mental health disorder and substance abuse. Include both of the following elements:</p> <p>1) Documented screening and brief counseling – Screenshots from electronic health record (EHR) or from other software/tools demonstrating integrated prevention and treatment interventions (e.g., evidence of screening and brief counseling for patients with mental health and substance abuse disorders); AND</p> <p>2) Evidence of percent of patients screened – 75% of ambulatory care patients are screened for unhealthy alcohol use.</p>	
IA_BMH_10	Behavioral and Mental Health	Completion of Collaborative Care Management Training Program	To receive credit for this activity, MIPS eligible clinicians must complete a collaborative care management training program, such as the American Psychiatric Association (APA) Collaborative Care Model training program available to the public, in order to implement a collaborative care management approach that	Medium	<p><u>Objective:</u> Develop strategies to improve integration of behavioral health into primary care practices, ultimately improving patient-centeredness of care and health outcomes for mental health patients.</p> <p><u>Validation Documentation:</u> Documented completion of a collaborative care management training program such as the American Psychological Association Collaborative Care Model training program. Include at least one of the following elements:</p>	2019

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
			provides comprehensive training in the integration of behavioral health into the primary care practice.		<p>1) Certificate of completion – Eligible clinicians and groups must provide authentic documentation of collaborative care management training program completion (electronic or paper); OR</p> <p>2) Implementation of approach – Documented implementation of a collaborative care management approach that provides comprehensive training in the integration of behavioral health into the primary care practice (e.g., a workflow diagram, listed staff and clinician roles and responsibilities, documented policies and procedures for approach).</p>	
IA_BMH_11	Behavioral and Mental Health	Implementation of a Trauma-Informed Care (TIC) Approach to Clinical Practice	<p>Create and implement a plan for trauma-informed care (TIC) that recognizes the potential impact of trauma experiences on patients and takes steps to mitigate the effects of adverse events in order to avoid re-traumatizing or triggering past trauma. Actions in this plan may include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Incorporate trauma-informed training into new employee orientation • Offer annual refreshers and/or trainings for all staff 	Medium	<p><u>Objective:</u> Ensure delivery of responsive care for patients and clinicians who have experienced physical or mental trauma.</p> <p><u>Validation Documentation:</u> Documentation of an implemented plan for delivering care to patients who have experienced trauma, and for addressing needs of clinicians and staff who have experienced trauma. Include the first element and one of the following elements:</p> <p>1) Implementation of a Trauma-Informed Care (TIC) plan – Documentation of the creation and implementation of a TIC plan; AND</p> <p>2) Training materials – Documentation of materials on TIC integrated into new employee orientation or</p>	2022

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
			<ul style="list-style-type: none"> • Recommend and supply TIC materials to third party partners, including care management companies and billing services • Identify patients using a screening methodology • Flag charts for patients with one or more adverse events that might have caused trauma • Use ICD-10 diagnosis codes for adverse events when appropriate <p>TIC is a strengths-based healthcare delivery approach that emphasizes physical, psychological, and emotional safety for both trauma survivors and their providers. Core components of a TIC approach are: awareness of the prevalence of trauma; understanding of the impact of past trauma on services utilization and engagement; and a commitment and plan to incorporate that understanding into training, policy, procedure, and practice.</p>		<p>annual employee training; OR</p> <p>3) TIC education materials – Documentation that materials on TIC are supplied to third-party partners, such as care management companies and billing services, to ensure a system-wide approach to TIC; OR</p> <p>4) Adverse events screener – Copy of implemented survey tool or prompt in electronic health record is used to assess and identify if a patient has experienced one or more adverse events that may have caused trauma.</p> <p><u>Information:</u></p> <ul style="list-style-type: none"> • Centers for Disease Control and Prevention’s Guiding Principles to Trauma-Informed Approach: https://www.cdc.gov/cpr/infographics/6_principles_trauma_info.htm • Substance Abuse and Mental Health Services Administration (SAMHSA). (2014). TIP 57: Trauma-informed care in behavioral health services: https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816?referrer=from_search_result. 	

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
IA_BMH_12	Behavioral and Mental Health	Promoting Clinician Well-Being	<p>Develop and implement programs to support clinician well-being and resilience—for example, through relationship-building opportunities, leadership development plans, or creation of a team within a practice to address clinician well-being—using one of the following approaches:</p> <ul style="list-style-type: none"> • Completion of clinician survey on clinician well-being with subsequent implementation of an improvement plan based on the results of the survey. • Completion of training regarding clinician well-being with subsequent implementation of a plan for improvement. 	High	<p><u>Objective:</u> Improve the well-being of clinicians and the quality and safety of care they deliver.</p> <p><u>Validation Documentation:</u> Evidence of activities to improve clinician well-being, defined by Chari et al. (2019) as a “concept that characterizes quality of life with respect to an individual’s health and work-related environmental, organizational, and psychosocial factors. Well-being is the experience of positive perceptions and the presence of constructive conditions at work and beyond that enables workers to thrive and achieve their full potential.” Include one of the following first two elements and the third element:</p> <ol style="list-style-type: none"> 1) Report on clinician well-being – Report including collected data on clinician well-being and resilience (e.g., survey results); OR 2) Staff training – Documentation of staff training on clinician well-being (e.g., training certificate, letter, training materials); AND 3) Implementation of a clinician well-being improvement plan – Documentation of a clinician well-being and resilience improvement plan, based on the results of the clinician well-being survey or staff training. 	2022

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
					<u>Information:</u> Chari et al. (2019). Expanding the Paradigm of Occupational Safety and Health: A New Framework for Worker Well-Being. Accessed September 5, 2021. Expanding the Paradigm of Occupational Safety and Health: A... : Journal of Occupational and Environmental Medicine (lww.com)	
IA_BMH_13	Behavioral and Mental Health	Obtain or Renew an Approved Waiver for Provision of Buprenorphine as Medication-Assisted Treatment for Opioid Use Disorder	Complete any required training and obtain or renew an approved waiver for provision of medication-assisted treatment of opioid use disorders using buprenorphine. Note: This activity may be selected once for low-capacity waivers, as these do not expire, and once every 3 years for the expanded waiver, in keeping with renewal requirements.	Medium	<p><u>Objective :</u> Improve access to treatment for opioid use disorder by increasing the number of providers authorized to prescribe buprenorphine.</p> <p><u>Validation Documentation:</u> Evidence of obtaining the approved waiver for provision of medication assisted treatment of opioid use disorders using buprenorphine. Include the following element: 1) Waiver – Substance Abuse and Mental Health Services Administration (SAMHSA) letter confirming presence of waiver and eligible clinician prescribing ID number.</p> <p><u>Example (s):</u> A primary care physician completed the buprenorphine waiver documentation, allowing her to prescribe buprenorphine to treat opioid use disorder to up to 30 patients.</p> <p><u>Information:</u></p> <ul style="list-style-type: none"> • This SAMHSA website explains how to become a 	2017

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
					<p>buprenorphine waived practitioner to treat opioid use disorder, with links to practice guidelines, optional training materials, and forms to file to request a waiver. "Become a Buprenorphine Waivered Practitioner." (https://www.samhsa.gov/medication-assisted-treatment/become-buprenorphine-waivered-practitioner)</p> <ul style="list-style-type: none"> This expert review in the American Journal of Obstetrics and Gynecology reviews updated guidelines for obtaining a waiver to prescribe buprenorphine. Training is no longer mandatory for some providers intending to prescribe for fewer than 30 patients. Cleary, E. M., Smid, M. C., Charles, J. E., Jones, K. M., Costantine, M. M., Saade, G., & Rood, K. M. (2021). Buprenorphine x-waiver exemption - beyond the basics for the obstetrical provider. American Journal of Obstetrics and Gynecology, 3(6), 100451. (https://doi.org/10.1016/j.ajogmf.2021.100451) 	
IA_PCMH	N/A	Electronic submission of Patient Centered Medical Home accreditation	N/A		<p><u>Objective:</u> Obtaining Patient-Centered Medical Home™ certification drives significant and sustainable practice improvements including population care quality, efficiency, and improved patient satisfaction all directly linked to better health outcomes.</p> <p><u>Validation Documentation:</u> Evidence of meeting performance standards and expectations pertaining to</p>	2017

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
					<p>the Patient-Centered Medical Home™ model. Include the following element:</p> <p>1) Recognition certificate – Documented recognition as a Patient-Centered Medical Home™ from a regional or state program, private payer, or other body that certifies at least 500 or more practices for Patient-Centered Medical Home™ accreditation or comparable specialty practice certification.</p> <p><u>Information:</u> Any clinician or group interested in attesting to IA_PCMH as their improvement activity must meet the criteria for recognition as a Patient-Centered Medical Home™ or comparable specialty practice participant. Information about criteria for a practice to be certified or recognized as a patient-centered medical home or comparable specialty practice can be found at the following in the Code of Federal Regulations (CFR [§ 414.1380(b)(3)(ii)]).</p>	

Version History

Date	Change Description
02/07/2023	Original version.

DOCUMENT PRODUCED IN NATIVE FORMAT

DOCUMENT PRODUCED IN NATIVE FORMAT

Quality Payment PROGRAM

2023 Merit-based Incentive Payment System (MIPS) Quality Performance Category Data Validation Information

For the 2023 performance period, please refer to the quality measure specifications and corresponding supporting documents within a collection type for the criteria used to determine the appropriate patient population (denominator) and quality action (numerator) for each selected quality measure. The measure specifications and supporting documents are the best resources to use to validate data related to each quality measure.

Supportive medical record and coding (Healthcare Common Procedure Coding System (HCPCS); Current Procedural Terminology (CPT); International Classification of Diseases, Tenth Revision (ICD-10); etc.) documentation maybe requested by the Centers for Medicare & Medicaid Services (CMS) to support data validation. Applicable coding for each measure is provided in the [2023 Medicare Part B Claims Measure Specifications and Supporting Documents \(ZIP\)](#), [2023 Clinical Quality Measure \(CQM\) Specifications and Supporting Documents \(ZIP\)](#), and [2023 Electronic Clinical Quality Measure \(eCQM\) Specifications](#) (click on the “Title” of an eCQM and then select the “Specifications and Data Elements” tab).

For questions related to the quality performance category, please contact the Quality Payment Program Service Center at 1-866-288-8292 or by e-mail at: QPP@cms.hhs.gov (Monday-Friday 8 a.m. - 8 p.m. ET). To receive assistance more quickly, please consider calling during non-peak hours—before 10 a.m. and after 2 p.m. ET.

- Customers who are hearing impaired can dial 711 to be connected to a TRS Communications Assistant.



Quality Payment PROGRAM

2023 MIPS Data Validation - Promoting Interoperability Performance Category Changes

Measure ID	Measure Name	2023 Changes
General	N/A	Changed date in all header cells from 2022 to 2023
PI_PPHI_2	High Priority Practices Guide of the Safety Assurance Factors for EHR Resilience (SAFER) Guides	Updated measure description
PI_HIE_5	Health Information Exchange (HIE) Bi-Directional Exchange	Updated measure description
PI_HIE_6	Enabling Exchange Under the Trusted Exchange Framework and Common Agreement (TEFCA)	Added measure for CY 2023
PI_EP_2	Query of Prescription Drug Monitoring Program (PDMP)	Updated measure to specify that it is now required. Updated measure description to include Schedule III drug and Schedule IV drug prescriptions.
PI_EP_2_EX_1	Query of Prescription Drug Monitoring Program (PDMP) Exclusion 1	Added measure exclusion for CY 2023
PI_EP_2_EX_2	Query of Prescription Drug Monitoring Program (PDMP) Exclusion 2	Added measure exclusion for CY 2023
PI_EP_2_EX_3	Query of Prescription Drug Monitoring Program (PDMP) Exclusion 3	Added measure exclusion for CY 2023
PI_PHCDRR_1_PRE	Immunization Registry Reporting Active Engagement Level 1	Added active engagement level measure for CY 2023



Measure ID	Measure Name	2023 Changes
PI_PHCDRR_1_PROD	Immunization Registry Active Engagement Level 2	Added active engagement level measure for CY 2023
PI_PHCDRR_2_PRE	Syndromic Surveillance Reporting Active Engagement Level 1	Added active engagement level measure for CY 2023
PI_PHCDRR_2_PROD	Syndromic Surveillance Reporting Active Engagement Level 2	Added active engagement level measure for CY 2023
PI_PHCDRR_3_EX_4	Electronic Case Reporting Exclusion 4	Removed measure exclusion (applicable for CY 2022 only)
PI_PHCDRR_3_PRE	Electronic Case Reporting Active Engagement Level 1	Added active engagement level measure for CY 2023
PI_PHCDRR_3_PROD	Electronic Case Active Engagement Level 2	Added active engagement level measure for CY 2023
PI_PHCDRR_4_PRE	Public Health Registry Reporting Active Engagement Level 1	Added active engagement level measure for CY 2023
PI_PHCDRR_4_PROD	Public Health Registry Reporting Active Engagement Level 2	Added active engagement level measure for CY 2023
PI_PHCDRR_5_PRE	Clinical Data Registry Reporting Active Engagement Level 1	Added active engagement level measure for CY 2023
PI_PHCDRR_5_PROD	Clinical Data Registry Reporting Active Engagement Level 2	Added active engagement level measure for CY 2023

Version History

Date	Change Description
02/07/2023	Original version.

Quality Payment PROGRAM

2023 MIPS Data Validation - Promoting Interoperability Performance Category Criteria

Measure ID	Measure Name	Measure Description	Required/ Bonus	Reporting Requirement	Validation	Suggested Documentation*
PI_PPHI_1	Security Risk Analysis	Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI data created or maintained by certified electronic health record technology (CEHRT) in accordance with requirements in 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), implement security updates as necessary, and correct identified security deficiencies as part of the MIPS eligible clinician's risk management process.	Required	Yes/No Statement	Security risk analysis of the CEHRT was performed or reviewed prior to the date of attestation on an annual basis and for the CEHRT used during the reporting period. • If you choose to submit for a 90-day MIPS performance period, it is acceptable for the security risk analysis to be conducted outside the performance period; however, it must be conducted within the calendar year of the MIPS performance period (January 1st – December 31st). An analysis must be done upon installation or upgrade to a new system and a review must be conducted covering each MIPS performance period.	A dated report or screenshot that documents the procedures performed during the analysis and the results. The report should be dated within the calendar year of the MIPS performance period and should include evidence to support that it was generated for that clinician's system (e.g., identified by National Provider Identifier (NPI), CMS Certification Number (CCN), clinician name, practice name, etc.). Notes: • The measure requires clinicians to address encryption/security of data stored in CEHRT. At minimum, clinicians should be able to show a plan for correcting or mitigating deficiencies and steps that are being taken to implement that plan. • Any documentation of an analysis will suffice; the report does not necessarily need to come from CEHRT.



Measure ID	Measure Name	Measure Description	Required/ Bonus	Reporting Requirement	Validation	Suggested Documentation*
PI_PPHI_2	High Priority Practices Guide of the Safety Assurance Factors for EHR Resilience (SAFER) Guides	Conduct an annual assessment of the High Priority Practices Guide SAFER Guide.	Required	Yes/No Statement	Submit a YES or NO to conducting an annual self-assessment of the High Priority Practices Guide of the SAFER Guides. (https://www.healthit.gov/topic/safety/safer-guides) for the 2023 performance period.	If submitting a "Yes": • A dated report or screenshot of the self-assessment checklist found on pages 5 – 6 of the Guide. OR • A dated report or screenshot of the recommended practice worksheets (1.1 – 3.3) on pages 9 – 26 of the Guide.
PI_EP_1	e-Prescribing	At least one permissible prescription written by the MIPS eligible clinician is transmitted electronically using CEHRT.	Required	Numerator/Denominator	At least one permissible prescription written by the MIPS eligible clinician is transmitted electronically via CEHRT.	A dated report or screenshot of patient prescription/record that indicates the number of times where electronic prescribing was performed in accordance with CMS standards for electronic prescribing (45 CFR 423.160(b)).
PI_LVPP_1	e-Prescribing Exclusion	Any MIPS eligible clinician who writes fewer than 100 permissible prescriptions during the performance period.	Required only if submitting an exclusion for the e-Prescribing measure. Measure ID PI_EP_1.	Yes	The 2018 QPP final rule finalized an exclusion for the e-Prescribing measure for any MIPS eligible clinician who writes fewer than 100 permissible prescriptions during the performance period. In order to submit an exclusion for this measure, MIPS eligible clinicians must select the exclusion for this measure. Any submission of a numerator or denominator for the e-Prescribing measure will void out the exclusion.	A dated report or screenshot from the CEHRT that shows the number of permissible prescriptions written by the MIPS eligible clinician during the performance period.
PI_EP_2	Query of Prescription Drug Monitoring Program (PDMP)	For at least one Schedule II opioid or Schedule III or IV drug electronically prescribed using CEHRT during the performance	Required	Yes/No Statement	Uses data from CEHRT to conduct a query of a PDMP for prescription drug history prior to electronically prescribing a patient	A dated report or screenshot that shows the MIPS eligible clinician used data from CEHRT to conduct a query of a PDMP for prescription

Measure ID	Measure Name	Measure Description	Required/ Bonus	Reporting Requirement	Validation	Suggested Documentation*
		period, the MIPS eligible clinician uses data from CEHRT to conduct a query of a PDMP for prescription drug history.			a Schedule II opioid, Schedule III drug or Schedule IV drug using CEHRT. The 2020 QPP final rule finalized removing the numerator and denominator previously established and instead requires a "yes/no" response beginning with the 2019 performance period.	drug history for at least one patient prior to electronically prescribing the patient a Schedule II opioid, Schedule III drug or Schedule IV drug.
PI_EP_2_EX_1	Query of Prescription Drug Monitoring Program (PDMP) Exclusion 1	MIPS eligible clinician is unable to electronically prescribe Schedule II opioids and Schedule III and IV drugs in accordance with applicable law during the performance period.	Required only if submitting an exclusion for the Query of Prescription Drug Monitoring Program measure. Measure ID PI_EP_2.	Yes	The 2023 QPP final rule finalized an exclusion for the Query of PDMP measure for any MIPS eligible clinician that is unable to electronically prescribe Schedule II opioids and Schedule III and IV drugs during the performance period. In order to submit an exclusion for this measure, MIPS eligible clinicians must select the exclusion for this measure. The submission of a "yes" for the Query of PDMP measure will void out the exclusion.	A written explanation of eligible clinician type or reference to the law.
PI_EP_2_EX_2	Query of Prescription Drug Monitoring Program (PDMP) Exclusion 2	MIPS eligible clinician writes fewer than 100 permissible prescriptions during the performance period.	Required only if submitting an exclusion for the Query of Prescription Drug Monitoring Program measure.	Yes	The 2023 QPP final rule finalized an exclusion for the Query of PDMP measure for any MIPS eligible clinician that writes fewer than 100 permissible to electronically prescribe Schedule II opioids and Schedule III and IV drugs during the performance period. In order to submit an exclusion for this measure, MIPS eligible clinicians must select the exclusion for this measure. The	A dated report or screenshot from the CEHRT that shows the number of permissible prescriptions written by the MIPS eligible clinician during the performance period.

Measure ID	Measure Name	Measure Description	Required/ Bonus	Reporting Requirement	Validation	Suggested Documentation*
			Measure ID PI_EP_2.		submission of a "yes" for the Query of PDMP measure will void out the exclusion.	
PI_EP_2_EX_3	Query of Prescription Drug Monitoring Program (PDMP) Exclusion 3	Querying a PDMP would impose an excessive workflow or cost burden prior to the start of the performance period they select in CY 2023.	Required only if submitting an exclusion for the Query of Prescription Drug Monitoring Program measure. Measure ID PI_EP_2.	Yes	The 2023 QPP final rule finalized an exclusion for the Query of PDMP measure for any MIPS eligible clinicians that believe that reporting this measure would impose an excessive workflow or cost burden. In order to submit an exclusion for this measure, MIPS eligible clinicians must select the exclusion for this measure. The submission of a "yes" for the Query of PDMP measure will void out the exclusion.	A written explanation of the excessive workflow or cost burden.
PI_HIE_1	Support Electronic Referral Loops by Sending Health Information	For at least one transition of care or referral, the MIPS eligible clinician that transitions or refers their patient to another setting of care or health care provider — (1) creates a summary of care record using certified electronic health record technology (CEHRT); and (2) electronically exchanges the summary of care record.	Required	Numerator/Denominator	When a patient is transitioned and/or referred to another setting or health care provider, the summary of care document must be generated by the CEHRT in a C-CDA format. The summary of care may be transmitted using a wide range of electronic options including secure email, Health Information Service Provider (HISP), query-based exchange or use of third party HIE.	A dated report or screenshot that indicates the number of summary of care documents that were created and exchanged electronically using CEHRT for transitions of care and/or referrals to another setting of care or health care provider during the performance period.
PI_LVOTC_1	Support Electronic Referral Loops by Sending Health Information Exclusion	Any MIPS eligible clinician who transfers a patient to another setting or refers a patient fewer than 100 times during the performance period.	Required only if submitting an exclusion	Yes	The 2018 QPP final rule finalized an exclusion for the Support Electronic Referral Loops by Sending Health Information measure for any MIPS eligible	A dated report or screenshot from the CEHRT that shows the number of times that the MIPS eligible clinician transfers and/or refers patients to another setting of care

Measure ID	Measure Name	Measure Description	Required/ Bonus	Reporting Requirement	Validation	Suggested Documentation*
			for the Support Electronic Referral Loops by Sending Health Information Measure.		clinician who transfers a patient to another setting and/or refers a patient fewer than 100 times during the performance period.	or to another health care provider during the performance period.
PI_HIE_4	Support Electronic Referral Loops by Receiving and Reconciling Health Information	For at least one electronic summary of care record received for patient encounters during the performance period for which a MIPS eligible clinician was the receiving party of a transition of care or referral, or for patient encounters during the performance period in which the MIPS eligible clinician has never before encountered the patient, the MIPS eligible clinician conducts clinical information reconciliation for medication, medication allergy, and current problem list.	Required	Numerator/Denominator	Receives or retrieves and reconciles an electronic summary care record into the CEHRT when a patient is transitioned or referred to the clinician AND performs review of medication(s), medication allergies, and current problem list and reconciliation for at least one transition of care or referral received, or patient encounter in which the MIPS eligible clinician has not before encountered the patient.	A dated report or screenshot that shows the number of times the MIPS eligible clinician: • electronically retrieved or received and reconciled a summary of care document into the CEHRT for a transition of care received, referral received, or patient encounter in which the MIPS eligible clinician has never before encountered the patient during the performance period. • performed clinical reconciliation for 1) medication, including the name, dosage, frequency, and route of each medication, 2) medication allergies, and 3) current problem list for a transition of care or referral received, or patient the MIPS eligible clinician has never before encountered during the performance period.
PI_LVITC_2	Support Electronic Referral Loops by Receiving and	Any MIPS eligible clinician who receives transitions of care or referrals or has patient	Required only if submitting	Yes	The 2020 QPP final rule revised the wording of this exclusion beginning with the 2019	A dated report or screenshot from the CEHRT that shows the number of times the MIPS eligible clinician

Measure ID	Measure Name	Measure Description	Required/ Bonus	Reporting Requirement	Validation	Suggested Documentation*
	Reconciling Health Information Exclusion	encounters in which the MIPS eligible clinician has never before encountered the patient fewer than 100 times during the performance period.	an exclusion for the Support Electronic Referral Loops by Receiving and Reconciling Health Information measure.		performance period: Any MIPS eligible clinician who receives transitions of care or referrals or has patient encounters in which the MIPS eligible clinician has never before encountered the patient fewer than 100 times during the performance period. The exclusion of less than 100 is any combination of transitions, referrals, or new patients.	receives a transition of care or referral or has patient encounters in which the clinician has never before encountered the patient during the performance period.
PI_HIE_5	Health Information Exchange (HIE) Bi-Directional Exchange	The MIPS eligible clinician or group must attest that they engage in bi-directional exchange with an HIE to support transitions of care.	Required only if submitting as an alternative to PI_HIE_1 and PI_HIE_4 or an alternative to PI_HIE_6.	Yes	Must establish the technical capacity and workflows to engage in bi-directional exchange via an HIE for all patients seen by the eligible clinician and for any patient record stored or maintained in their EHR, consistent with their attestation statements.	<ul style="list-style-type: none"> • A dated report or screenshot that documents successful receipt and transmission of patient data via the entity providing health information exchange services. Should include evidence to support that it was generated for that MIPS eligible clinician's system (e.g., identified by National Provider Identifier (NPI), clinician name, practice name, etc.). AND/OR • Letter, email or other documentation from the entity providing health information exchange services confirming participation of MIPS eligible clinician, the date of on-boarding, a description of services provided, and a description of exchange network participants (e.g.

Measure ID	Measure Name	Measure Description	Required/ Bonus	Reporting Requirement	Validation	Suggested Documentation*
						number/type of participating providers). OR <ul style="list-style-type: none"> Letter, email or other documentation from the MIPS eligible clinician's CEHRT vendor confirming a connection between the eligible clinician's CEHRT and an entity providing health information exchange services, the date of on-boarding, a description of services provided, and a description of exchange network participants (e.g. number/type of participating providers) for the duration of the performance period.
PI_HIE_6	Enabling Exchange Under the Trusted Exchange Framework and Common Agreement (TEFCA)	<p>The MIPS eligible clinician or group must attest that they engage in bi-directional exchange with an HIE to support transitions of care.to the following:</p> <ul style="list-style-type: none"> Participating as a signatory to a Framework Agreement (as that term is defined by the Common Agreement for Nationwide Health Information Interoperability as published in the Federal Register and on ONC's website) in good standing (i.e. not suspended) and enabling secure, bidirectional exchange of information to occur, in 	Required only if submitting as an alternative to PI_HIE_1 and PI_HIE_4 or an alternative to PI_HIE_5	Yes	<p>The MIPS eligible clinician must</p> <ul style="list-style-type: none"> Participate as a signatory to a Framework Agreement in good standing (i.e. not suspended) and enabling secure, bidirectional exchange of information to occur, in production, for every patient encounter, transition or referral, and record stored or maintained in the EHR during the performance period, in accordance with applicable law and policy.. Uses the functions of CEHRT to support bi-directional exchange of patient information, in production, under this Framework Agreement. 	<ul style="list-style-type: none"> A dated report or screenshot that documents successful receipt and transmission of patient data via the entity providing health information exchange services. Should include evidence to support that it was generated for that MIPS eligible clinician's system (e.g., identified by National Provider Identifier (NPI), clinician name, practice name, etc.). <p>AND/OR</p> <ul style="list-style-type: none"> Letter, email or other documentation from the entity providing health information exchange services confirming participation of MIPS eligible clinician, the date of on-boarding, a

Measure ID	Measure Name	Measure Description	Required/ Bonus	Reporting Requirement	Validation	Suggested Documentation*
		production, for every patient encounter, transition or referral, and record stored or maintained in the EHR during the performance period, in accordance with applicable law and policy.. • Using the functions of CEHRT to support bi-directional exchange of patient information, in production, under this Framework Agreement.				description of services provided, and a description of exchange network participants (e.g. number/type of participating providers). OR • Letter, email or other documentation from the MIPS eligible clinician's CEHRT vendor confirming a connection between the eligible clinician's CEHRT and an entity providing health information exchange services, the date of on-boarding, a description of services provided, and a description of exchange network participants (e.g. number/type of participating providers) for the duration of the performance period.
PI_PEA_1	Provide Patients Electronic Access to Their Health Information	For at least one unique patient seen by the MIPS eligible clinician: (1) The patient (or the patient-authorized representative) is provided timely access to view online, download, and transmit his or her health information; and (2) The MIPS eligible clinician ensures the patient's health information is available for the patient (or patient-authorized representative) to access using any application of their choice that is configured to	Required	Numerator/Denominator	Provide the information necessary to grant access to the patient or their authorized representative in order to view, download, and transmit their health information using any application of the patient's choice meeting the technical specifications of the application programming interface of the clinician's CEHRT.	A dated report or screenshot that documents the number of times a patient or patient-authorized representative is given access to view, download, or transmit their health information. This could include instructions provided to the patient on how to access their health information, including: the website address they must visit, the patient's unique and registered username or password, and a record of the patient logging on to show that the patient can use any application of their choice to access

Measure ID	Measure Name	Measure Description	Required/ Bonus	Reporting Requirement	Validation	Suggested Documentation*
		meet the technical specifications of the Application Programming Interface (API) in the MIPS eligible clinician's certified electronic health record technology (CEHRT).				the information and meet the API technical specifications.
PI_PHCDRR_1	Immunization Registry Reporting	The MIPS eligible clinician is in active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS).	Required	Yes/No Statement	Active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the registry/immunization information system.	<ul style="list-style-type: none"> • A dated report or screenshot that document successful registration or submission to the registry or public health agency. Should include evidence to support that it was generated for that MIPS eligible clinician's system (e.g., identified by National Provider Identifier (NPI), clinician name, practice name, etc.). Or • A dated report or screenshot of successful electronic transmission (e.g., screenshot from another system, etc.). Should include evidence to support that it was generated for that MIPS eligible clinician (e.g., identified by National Provider Identifier (NPI), clinician name, practice name, etc.). Or • Letter or email from registry or public health agency confirming registration or receipt of submitted data, including the date of the submission and name of sending and receiving parties.

Measure ID	Measure Name	Measure Description	Required/ Bonus	Reporting Requirement	Validation	Suggested Documentation*
PI_PHCDRR_1_EX_1	Immunization Registry Reporting Exclusion 1	Any MIPS eligible clinician who does not administer any immunizations to any of the populations for which data is collected by its jurisdiction's immunization registry or immunization information system during the performance period.	Required only if submitting an exclusion for the Immunization Registry Reporting measure (PI_PHCDRR_1) and the other exclusions (PI_PHCDRR_1_EX_2 or PI_PHCDRR_1_EX_3) do not apply.	Yes	The 2019 QPP final rule finalized an exclusion for the Immunization Registry Reporting measure for a MIPS eligible clinician who does not administer any immunizations to any of the populations for which data is collected by its jurisdiction's immunization registry or immunization information system during the performance period.	A dated report or screenshot that indicates that the MIPS eligible clinician did not administer any immunizations to any population for which data is collected by its jurisdiction's immunization registry or immunization information system during the performance period.
PI_PHCDRR_1_EX_2	Immunization Registry Reporting Exclusion 2	Support Electronic Referral Loops By Receiving and Reconciling Health Information Exclusion	Required only if submitting an exclusion for the Immunization Registry Reporting measure (PI_PHCDRR_1) and the other	Yes	The 2019 QPP final rule finalized an exclusion for the Immunization Registry Reporting measure for a MIPS eligible clinician who operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required to meet the CEHRT definition at the start of the performance period.	For exclusions to Public Health and Clinical Data Exchange objective, a dated report or screenshot or letter or email from the registry that demonstrates the MIPS eligible clinician was unable to submit and would, therefore, qualify under one of the provided exclusions to the objective.

Measure ID	Measure Name	Measure Description	Required/ Bonus	Reporting Requirement	Validation	Suggested Documentation*
			exclusions (PI_PHCD RR_1_EX_ 1 or PI_PHCDR R_1_EX_3) do not apply.			
PI_PHCDRR_1 _EX_3	Immunization Registry Reporting Exclusion 3	Any MIPS eligible clinician who operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data as of 6 months prior to the start of the performance period.	Required only if submitting an exclusion for the Immunization Registry Reporting measure (PI_PHCDRR_1) and the other exclusions (PI_PHCDRR_1_EX_1 or PI_PHCDRR_1_EX_2) do not apply.	Yes	The 2019 QPP final rule finalized an exclusion for the Immunization Registry Reporting measure for a MIPS eligible clinician who operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data as of 6 months prior to the start of the performance period.	For exclusions to Public Health and Clinical Data Exchange objective, a dated report or screenshot or letter or email from the registry that demonstrates the MIPS eligible clinician was unable to submit and would, therefore, qualify under one of the provided exclusions to the objective.
PI_PHCDRR_1 _PRE	Immunization Registry Reporting Active Engagement Level 1	Option 1 – Pre-Production and Validation: The MIPS eligible clinician must first register to submit data with the PHA or, where applicable, the clinical	Required only if PI_PHCDR_1_PROD	Yes	The 2023 QPP final rule finalized that MIPS eligible clinicians must submit their level of active engagement, either OPTION 1 (Pre-production and Validation) or	•A dated report or screenshot that document successful registration or submission to the registry or public health agency. Should include evidence to support that it was

Measure ID	Measure Name	Measure Description	Required/ Bonus	Reporting Requirement	Validation	Suggested Documentation*
		data registry (CDR) to which the information is being submitted. Registration must be completed within 60 days after the start of the performance period, while awaiting an invitation from the PHA or CDR to begin testing and validation. Upon completion of the initial registration, the MIPS eligible clinician must begin the process of testing and validation of the electronic submission of data. The MIPS eligible clinician must respond to requests from the PHA or, where applicable, the CDR within 30 days; failure to respond twice within a performance period would result in the MIPS eligible clinician not meeting the measure.	does not apply.		OPTION 2 (Validated Data Production) for each measure they report beginning with the performance period in CY 2023.	generated for that MIPS eligible clinician's system (e.g., identified by National Provider Identifier (NPI), clinician name, practice name, etc.). Or • A dated report or screenshot of successful electronic transmission (e.g., screenshot from another system, etc.). Should include evidence to support that it was generated for that MIPS eligible clinician (e.g., identified by National Provider Identifier (NPI), clinician name, practice name, etc.). Or • Letter or email from registry or public health agency confirming registration or receipt of submitted data, including the date of the submission and name of sending and receiving parties.
PI_PHCDRR_1_PROD	Immunization Registry Active Engagement Level 2	Option 2 – Validated Data Production: The MIPS eligible clinician has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA or CDR.	Required only if PI_PHCDRR_1_PRE does not apply.	Yes	The 2023 QPP final rule finalized that MIPS eligible clinicians must submit their level of active engagement, either OPTION 1 (Pre-production and Validation) or OPTION 2 (Validated Data Production) for each measure they report beginning with the performance period in CY 2023.	A dated report or screenshot of successful electronic transmissions (e.g., screenshot from another system, etc.). Should include evidence to support that it was generated for that MIPS eligible clinician (e.g., identified by National Provider Identifier (NPI), clinician name, practice name, etc.).
PI_PHCDRR_2	Syndromic Surveillance Reporting	The MIPS eligible clinician is in active engagement with a public health agency to submit	Bonus	Yes/No Statement	Active engagement with a public health agency or clinical data registry to submit syndromic	• A dated report or screenshot from CEHRT that document successful registration or submission to the

Measure ID	Measure Name	Measure Description	Required/ Bonus	Reporting Requirement	Validation	Suggested Documentation*
		syndromic surveillance data from an urgent care setting.			surveillance data from an urgent care setting where the jurisdiction accepts syndromic data from such settings and the standards are clearly defined. The 2020 QPP final rule confirmed the measure description for the Syndromic Surveillance Reporting measure as follows: "The MIPS eligible clinician is in active engagement with a public health agency to submit syndromic surveillance data from an urgent care setting".	registry or public health agency. Should include evidence to support that it was generated for that MIPS eligible clinician's system (e.g., identified by National Provider Identifier (NPI), clinician name, practice name, etc.). OR • A dated report or screenshot of successful electronic transmission (e.g., screenshot from another system, etc.). Should include evidence to support that it was generated for that MIPS eligible clinician (e.g., identified by National Provider Identifier (NPI), clinician name, practice name, etc.). OR • Letter or email from registry or public health agency confirming registration or receipt of submitted data, including the date of the submission and name of sending and receiving parties.
PI_PHCDRR_2_PRE	Syndromic Surveillance Reporting Active Engagement Level 1	Option 1 – Pre-Production and Validation: The MIPS eligible clinician must first register to submit data with the PHA or, where applicable, the clinical data registry (CDR) to which the information is being submitted. Registration must be completed within 60 days after the start of the performance period, while	Required only if reporting the Syndromic Surveillance Reporting Measure (PI_PHCDRR_2) and	Yes	The 2023 QPP final rule finalized that MIPS eligible clinicians must submit their level of active engagement, either OPTION 1 (Pre-production and Validation) or OPTION 2 (Validated Data Production) for each measure they report beginning with the performance period in CY 2023.	• A dated report or screenshot that document successful registration or submission to the registry or public health agency. Should include evidence to support that it was generated for that MIPS eligible clinician's system (e.g., identified by National Provider Identifier (NPI), clinician name, practice name, etc.).

Measure ID	Measure Name	Measure Description	Required/ Bonus	Reporting Requirement	Validation	Suggested Documentation*
		awaiting an invitation from the PHA or CDR to begin testing and validation. Upon completion of the initial registration, the MIPS eligible clinician must begin the process of testing and validation of the electronic submission of data. The MIPS eligible clinician must respond to requests from the PHA or, where applicable, the CDR within 30 days; failure to respond twice within a performance period would result in the MIPS eligible clinician not meeting the measure.	PI_PHCDRR_2_PROD does not apply.			Or• Letter or email from registry or public health agency confirming registration or receipt of submitted data, including the date of the submission and name of sending and receiving parties.
PI_PHCDRR_2_PROD	Syndromic Surveillance Reporting Active Engagement Level 2	Option 2 – Validated Data Production: The MIPS eligible clinician has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA or CDR.	Required only if reporting the Syndromic Surveillance Reporting Measure (PI_PHCDRR_2) and PI_PHCDRR_2_PRE does not apply.	Yes	The 2023 QPP final rule finalized that MIPS eligible clinicians must submit their level of active engagement, either OPTION 1 (Pre-production and Validation) or OPTION 2 (Validated Data Production) for each measure they report beginning with the performance period in CY 2023.	A dated report or screenshot of successful electronic transmissions (e.g., screenshot from another system, etc.). Should include evidence to support that it was generated for that MIPS eligible clinician (e.g., identified by National Provider Identifier (NPI), clinician name, practice name, etc.).
PI_PHCDRR_3	Electronic Case Reporting	The MIPS eligible clinician is in active engagement with a public health agency to electronically	Required	Yes/No Statement	Active engagement with a public health agency or clinical data registry to electronically submit	• A dated report or screenshot from CEHRT that document successful registration or submission to the registry or public health agency.

Measure ID	Measure Name	Measure Description	Required/ Bonus	Reporting Requirement	Validation	Suggested Documentation*
		submit case reporting of reportable conditions.			case reporting of reportable conditions.	Should include evidence to support that it was generated for that MIPS eligible clinician's system (e.g., identified by National Provider Identifier (NPI), clinician name, practice name, etc.). OR • A dated report or screenshot of successful electronic transmission (e.g., screenshot from another system, etc.). Should include evidence to support that it was generated for that MIPS eligible clinician (e.g., identified by National Provider Identifier (NPI), clinician name, practice name, etc.). OR • Letter or email from registry or public health agency confirming registration or receipt of submitted data, including the date of the submission and name of sending and receiving parties.
PI_PHCDRR_3_EX_1	Electronic Case Reporting Exclusion 1	Any MIPS eligible clinician who does not treat or diagnose any reportable diseases for which data is collected by their jurisdiction's reportable disease system during the performance period.	Required only if submitting an exclusion for the Electronic Case Reporting measure (PI_PHCD	Yes	The 2019 QPP final rule finalized an exclusion for the Electronic Case Reporting measure for a MIPS eligible clinician who does not treat or diagnose any reportable diseases for which data is collected by their jurisdiction's reportable disease system during the performance period.	A dated report or screenshot that indicates that the MIPS eligible clinician does not treat or diagnose any reportable diseases for which data is collected by the jurisdiction's reportable disease system during the performance period.

Measure ID	Measure Name	Measure Description	Required/ Bonus	Reporting Requirement	Validation	Suggested Documentation*
			RR_3) and the other exclusions (PI_PHCD RR_3_EX_2 or PI_PHCD R_3_EX_3) do not apply.			
PI_PHCDRR_3_EX_2	Electronic Case Reporting Exclusion 2	Any MIPS eligible clinician who operates in a jurisdiction for which no public health agency is capable of receiving electronic case reporting data in the specific standards required to meet the CEHRT definition at the start of the performance period.	Required only if submitting an exclusion for the Electronic Case Reporting measure (PI_PHCD RR_3) and the other exclusions (PI_PHCD RR_3_EX_1 or PI_PHCD R_3_EX_3) do not apply.	Yes	The 2019 QPP final rule finalized an exclusion for the Electronic Case Reporting measure for a MIPS eligible clinician who operates in a jurisdiction for which no public health agency is capable of receiving electronic case reporting data in the specific standards required to meet the CEHRT definition at the start of the performance period.	For exclusions to Public Health and Clinical Data Exchange objective, a dated report or screenshot or letter or email from the registry that demonstrates the MIPS eligible clinician was unable to submit and would, therefore, qualify under one of the provided exclusions to the objective.
PI_PHCDRR_3_EX_3	Electronic Case Reporting Exclusion 3	Any MIPS eligible clinician who operates in a jurisdiction where no public health agency has	Required only if submitting	Yes	The 2019 QPP final rule finalized an exclusion for the Electronic Case Reporting measure for a	For exclusions to Public Health and Clinical Data Exchange objective, a dated report or screenshot or letter

Measure ID	Measure Name	Measure Description	Required/ Bonus	Reporting Requirement	Validation	Suggested Documentation*
		declared readiness to receive electronic case reporting data as of 6 months prior to the start of the performance period.	an exclusion for the Electronic Case Reporting measure (PI_PHCD RR_3) and the other exclusions (PI_PHCD RR_3_EX_1 or PI_PHCD R_3_EX_2) do not apply.		MIPS eligible clinician who operates in a jurisdiction where no public health agency has declared readiness to receive electronic case reporting data as of 6 months prior to the start of the performance period.	or email from the registry that demonstrates the MIPS eligible clinician was unable to submit and would, therefore, qualify under one of the provided exclusions to the objective.
PI_PHCDRR_3_PRE	Electronic Case Reporting Active Engagement Level 1	Option 1 – Pre-Production and Validation: The MIPS eligible clinician must first register to submit data with the PHA or, where applicable, the clinical data registry (CDR) to which the information is being submitted. Registration must be completed within 60 days after the start of the performance period, while awaiting an invitation from the PHA or CDR to begin testing and validation. Upon completion of the initial registration, the MIPS eligible clinician must begin the process of testing and	Required only if PI_PHCD R_3_PROD does not apply.	Yes	The 2023 QPP final rule finalized that MIPS eligible clinicians must submit their level of active engagement, either OPTION 1 (Pre-production and Validation) or OPTION 2 (Validated Data Production) for each measure they report beginning with the performance period in CY 2023.	<ul style="list-style-type: none"> • A dated report or screenshot that document successful registration or submission to the registry or public health agency. Should include evidence to support that it was generated for that MIPS eligible clinician's system (e.g., identified by National Provider Identifier (NPI), clinician name, practice name, etc.). Or • Letter or email from registry or public health agency confirming registration or receipt of submitted data, including the date of the

Measure ID	Measure Name	Measure Description	Required/ Bonus	Reporting Requirement	Validation	Suggested Documentation*
		validation of the electronic submission of data. The MIPS eligible clinician must respond to requests from the PHA or, where applicable, the CDR within 30 days; failure to respond twice within a performance period would result in the MIPS eligible clinician not meeting the measure.				submission and name of sending and receiving parties.
PI_PHCDRR_3_PROD	Electronic Case Reporting Active Engagement Level 2	Option 2 – Validated Data Production: The MIPS eligible clinician has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA or CDR.	Required only if PI_PHCDRR_3_PRE does not apply.	Yes	The 2023 QPP final rule finalized that MIPS eligible clinicians must submit their level of active engagement, either OPTION 1 (Pre-production and Validation) or OPTION 2 (Validated Data Production) for each measure they report beginning with the performance period in CY 2023.	A dated report or screenshot of successful electronic transmissions (e.g., screenshot from another system, etc.). Should include evidence to support that it was generated for that MIPS eligible clinician (e.g., identified by National Provider Identifier (NPI), clinician name, practice name, etc.).
PI_PHCDRR_4	Public Health Registry Reporting	The MIPS eligible clinician is in active engagement with a public health agency to submit data to public health registries.	Bonus	Yes/No Statement	Active engagement with a public health agency or clinical data registry to electronically submit data to public health registries.	<ul style="list-style-type: none"> • A dated report or screenshot from CEHRT that document successful registration or submission to the registry or public health agency. Should include evidence to support that it was generated for that MIPS eligible clinician's system (e.g., identified by National Provider Identifier (NPI), clinician name, practice name, etc.). OR • A dated report or screenshot of successful electronic transmission (e.g., screenshot from another system, etc.). Should include

Measure ID	Measure Name	Measure Description	Required/ Bonus	Reporting Requirement	Validation	Suggested Documentation*
						evidence to support that it was generated for that MIPS eligible clinician (e.g., identified by National Provider Identifier (NPI), clinician name, practice name, etc.). OR • Letter or email from registry or public health agency confirming registration or receipt of submitted data, including the date of the submission and name of sending and receiving parties.
PI_PHCDRR_4_PRE	Public Health Registry Reporting Active Engagement Level 1	Option 1 – Pre-Production and Validation: The MIPS eligible clinician must first register to submit data with the PHA or, where applicable, the clinical data registry (CDR) to which the information is being submitted. Registration must be completed within 60 days after the start of the performance period, while awaiting an invitation from the PHA or CDR to begin testing and validation. Upon completion of the initial registration, the MIPS eligible clinician must begin the process of testing and validation of the electronic submission of data. The MIPS eligible clinician must respond to requests from the PHA or, where applicable, the CDR within 30 days; failure to	Required only if reporting the Syndromic Surveillance Reporting Measure (PI_PHCDRR_4) and PI_PHCDRR_4_PROD does not apply.	Yes	The 2023 QPP final rule finalized that MIPS eligible clinicians must submit their level of active engagement, either OPTION 1 (Pre-production and Validation) or OPTION 2 (Validated Data Production) for each measure they report beginning with the performance period in CY 2023.	•A dated report or screenshot that document successful registration or submission to the registry or public health agency. Should include evidence to support that it was generated for that MIPS eligible clinician's system (e.g., identified by National Provider Identifier (NPI), clinician name, practice name, etc.). Or • Letter or email from registry or public health agency confirming registration or receipt of submitted data, including the date of the submission and name of sending and receiving parties.

Measure ID	Measure Name	Measure Description	Required/ Bonus	Reporting Requirement	Validation	Suggested Documentation*
		respond twice within a performance period would result in the MIPS eligible clinician not meeting the measure.				
PI_PHCDRR_4_PROD	Public Health Registry Reporting Active Engagement Level 2	Option 2 – Validated Data Production: The MIPS eligible clinician has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA or CDR.	Required only if reporting the Syndromic Surveillance Reporting Measure (PI_PHCDRR_4) and PI_PHCDRR_4_PRE does not apply.	Yes	The 2023 QPP final rule finalized that MIPS eligible clinicians must submit their level of active engagement, either OPTION 1 (Pre-production and Validation) or OPTION 2 (Validated Data Production) for each measure they report beginning with the performance period in CY 2023.	A dated report or screenshot of successful electronic transmissions (e.g., screenshot from another system, etc.). Should include evidence to support that it was generated for that MIPS eligible clinician (e.g., identified by National Provider Identifier (NPI), clinician name, practice name, etc.).
PI_PHCDRR_5	Clinical Data Registry Reporting	The MIPS eligible clinician is in active engagement to submit data to a clinical data registry.	Bonus	Yes/No Statement	Active engagement with a clinical data registry to electronically submit clinical data.	<ul style="list-style-type: none"> • A dated report or screenshot from the CEHRT that document successful registration or submission to the registry or public health agency. Should include evidence to support that it was generated for that MIPS eligible clinician's system (e.g., identified by National Provider Identifier (NPI), clinician name, practice name, etc.). OR <ul style="list-style-type: none"> • A dated report or screenshot of successful electronic transmission (e.g., screenshot from another system, etc.). Should include

Measure ID	Measure Name	Measure Description	Required/ Bonus	Reporting Requirement	Validation	Suggested Documentation*
						evidence to support that it was generated for that MIPS eligible clinician (e.g., identified by National Provider Identifier (NPI), clinician name, practice name, etc.). OR • Letter or email from registry or public health agency confirming registration or receipt of submitted data, including the date of the submission and name of sending and receiving parties.
PI_PHCDRR_5_PRE	Clinical Data Registry Reporting Active Engagement Level 1	Option 1 – Pre-Production and Validation: The MIPS eligible clinician must first register to submit data with the PHA or, where applicable, the clinical data registry (CDR) to which the information is being submitted. Registration must be completed within 60 days after the start of the performance period, while awaiting an invitation from the PHA or CDR to begin testing and validation. Upon completion of the initial registration, the MIPS eligible clinician must begin the process of testing and validation of the electronic submission of data. The MIPS eligible clinician must respond to requests from the PHA or, where applicable, the CDR within 30 days; failure to	Required only if reporting the Syndromic Surveillance Reporting Measure (PI_PHCDRR_5) and PI_PHCDRR_5_PROD does not apply.	Yes	The 2023 QPP final rule finalized that MIPS eligible clinicians must submit their level of active engagement, either OPTION 1 (Pre-production and Validation) or OPTION 2 (Validated Data Production) for each measure they report beginning with the performance period in CY 2023.	•A dated report or screenshot that document successful registration or submission to the registry or public health agency. Should include evidence to support that it was generated for that MIPS eligible clinician's system (e.g., identified by National Provider Identifier (NPI), clinician name, practice name, etc.). Or • Letter or email from registry or public health agency confirming registration or receipt of submitted data, including the date of the submission and name of sending and receiving parties.

Measure ID	Measure Name	Measure Description	Required/ Bonus	Reporting Requirement	Validation	Suggested Documentation*
		respond twice within a performance period would result in the MIPS eligible clinician not meeting the measure.				
PI_PHCDRR_5_PROD	Clinical Data Registry Reporting Active Engagement Level 2	Option 2 – Validated Data Production: The MIPS eligible clinician has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA or CDR.	Required only if reporting the Syndromic Surveillance Reporting Measure (PI_PHCDRR_5) and PI_PHCDRR_5_PRE does not apply.	Yes	The 2023 QPP final rule finalized that MIPS eligible clinicians must submit their level of active engagement, either OPTION 1 (Pre-production and Validation) or OPTION 2 (Validated Data Production) for each measure they report beginning with the performance period in CY 2023.	A dated report or screenshot of successful electronic transmissions (e.g., screenshot from another system, etc.). Should include evidence to support that it was generated for that MIPS eligible clinician (e.g., identified by National Provider Identifier (NPI), clinician name, practice name, etc.).

Version History

Date	Change Description
02/07/2023	Original version.
04/06/2023	Updated PI_EP_2 description to include Schedule III drug and Schedule IV drug prescriptions.

* Documentation needs to be from certified electronic health record technology (CEHRT) and be inclusive of:

- 1) The time period the report covers (performance period),
- 2) Clinician identification, e.g., National Provider Identifier (NPI), and
- 3) Evidence to support that the report was generated by the CEHRT (e.g., screenshot of the report before it was printed from the system).

Because some CEHRT are unable to generate reports that limit the calculation of measures to a prior time period, CMS suggests that clinicians download and/or print a copy of the report used at the time of data submission for their records.

From: CMS Health Equity TA
To: Megan Coffman; Kelsey Besse; park.diana@norc.org; Phoebe Lamuda
Subject: Fw: [EXTERNAL] Re: NQP template
Date: Wednesday, September 20, 2023 10:59:19 AM
Attachments: image001.png
image002.png

From: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>
Sent: Wednesday, September 20, 2023 10:58 AM
To: Hawk, shoshanna <shoshanna.Hawk@kindred.com>
Subject: Re: [EXTERNAL] Re: NQP template

Dear Shoshanna,

It might be helpful to have a 30-minute call to discuss your DIS. Our team is available to talk through your DIS the following dates and times:

Tuesday 9/26: 11:30 - 12 PM ET, 3 - 4 PM ET
Thursday 9/28: 11:30 - 12 PM ET

Let me know if any of these times work for you and we can send out an invitation.

Also, please share any additional materials you think may be helpful for us to review prior to the call.

Thank you,
Phoebe on behalf of TA team

From: Hawk, shoshanna <shoshanna.Hawk@kindred.com>
Sent: Wednesday, September 13, 2023 11:17 PM
To: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>
Subject: RE: [EXTERNAL] Re: NQP template

Hi Team,

First let me say thank you for taking the time to send me this worksheet and instructions. As I am filing this out, I am not sure if we need to be more specific as tackling the homeless in Las Vegas has many dimensions. Could someone review what we have drafted to give some more meat to it as I am wondering if we need to maybe just address the access to mental health services and housing rather than all the areas that we are presented with when supporting this population. I was also wondering how others captured the race and ethnicity portion if it is not tracked by our organization.

Thanks
Shanna

Shoshanna Hawk, RN, BSN

Director of Case Management
Las Vegas Sahara Kindred
O:702-790-0861
C:216-543-4665
Shoshanna.hawk@kindred.com
www.kindred.com



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From: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>
Sent: Wednesday, September 13, 2023 3:58 PM

To: Hawk, shoshanna <shoshanna.Hawk@kindred.com>

Subject: [EXTERNAL] Re: NQP template

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Please report any suspicious e-mail by clicking on the "Report Phishing" icon or by forwarding the e-mail to Phishing@lpnt.net.

Dear Shoshanna,

Thank you for reaching out to the CMS OMH Health Equity Technical Assistance mailbox. You can find a blank Action Template at the end of the [Disparities Impact Statement Tool](#).

Thank you for your work advancing health equity,

Health Equity Technical Assistance Team

HealthEquityTA@cms.hhs.gov

CMS Office of Minority Health

Visit us at go.cms.gov/healthequityTA | go.cms.gov/healthequityTA



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From: Hawk, shoshanna <shoshanna.Hawk@kindred.com>

Sent: Monday, September 11, 2023 9:16 PM

To: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>

Subject: NQP template

Good Evening,

I was wondering if you had a blank Action plan template that I could use to fill out. At our facility we are going to address our Homeless population in the Las Vegas Nevada area and I noted another facility in Florida has created a template for their action plan received from you.

Thanks

Shanna

Shoshanna Hawk, RN, BSN

Director of Case Management

Las Vegas Sahara Kindred

O:702-790-0861

C:216-543-4665

Shoshanna.hawk@kindred.com

www.kindred.com



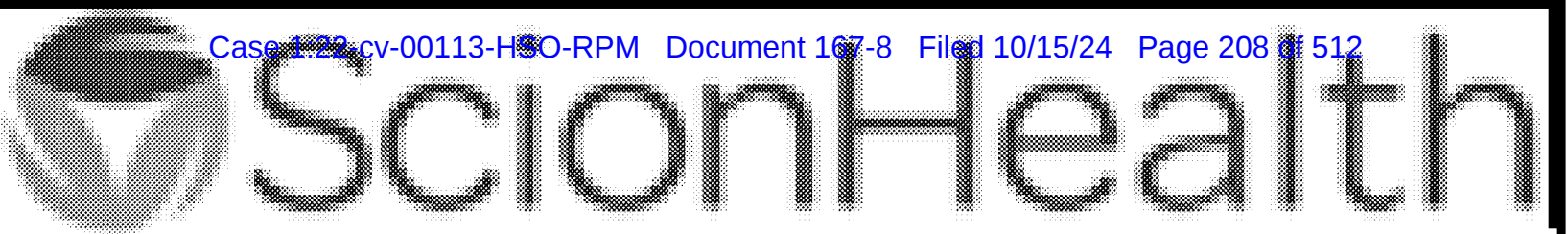
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Case Management
Mountain District



THE MOUNTAIN DISTRICT





“Working to Achieve Health Equity”

From: [CMS Health Equity TA](#)
To: [Phoebe Lamuda](#); park-diana@norc.org; [Lauren Isaacs](#)
Subject: Fw: Healing Hands Healthcare
Date: Thursday, April 4, 2024 4:16:12 PM
Attachments: [image001.png](#)
[Outlook-q3hfveak.png](#)
[Outlook-w5ms5d4h.png](#)
[image.png](#)

Confirmed that there has not been a response to the below email, so per CMS OMH guidance today, we can consider this request closed.

From: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>
Sent: Friday, March 15, 2024 4:50 PM
To: Nichole Jefferson <njefferson@healinghandshealthcare.us>
Subject: Re: Healing Hands Healthcare

Hi Nichole,

Thank you for your patience while we coordinated schedules. Are you free for a 30-minute conversation at any of the below times:

Monday April 1, 2024: 10:30-11:00 AM ET; 12:30-1:00 PM ET

Tuesday April 2, 2024: 10:30-11:00 AM ET; 1:30-2:00 PM ET; 3:00-3:30 PM ET

Thank you,

Health Equity Technical Assistance Team

HealthEquityTA@cms.hhs.gov

CMS Office of Minority Health

Visit us at go.cms.gov/healthequityTA



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From: Nichole Jefferson <njefferson@healinghandshealthcare.us>

Sent: Friday, February 9, 2024 10:44 AM

To: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>

Subject: Re: Healing Hands Healthcare

Hello,

Thank you for providing these resources, however I will need to be able to discuss this with someone to gain the appropriate understanding regarding identifying health equity, how to interpret the data, and developing a strategic plan with the resources provided. I am an audio/visual learner and I will need to be able to ask questions from an expert to fully comprehend the issues at hand.

Can you please provide me with a scheduled call.



NICHOLE JEFFERSON, M.L.S. HEALTHCARE LAW,
BSW, RH, CCS-C
DIRECTOR OF COMPLIANCE

(940) 432-0588

(940) 238-5340

(940) 432-0275

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WICHITA FALLS, TX 76301

Compliance Hotline: www.hotline-services.com or 1-855-252-7606

From: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>

Sent: Wednesday, January 10, 2024 8:56 AM

To: Nichole Jefferson <njefferson@healinghandshealthcare.us>

Subject: Re: Healing Hands Healthcare

You don't often get email from healthequityta@cms.hhs.gov. [Learn why this is important](#)

Dear Nichole,

Based on the areas you listed on wanting to receive assistance, we put together a list of resources to get you started.

1. As a first step to building a strategic plan around your health equity goals, we encourage you to review and complete the [CMS Disparities Impact Statement](#). This is a straightforward step-by-step worksheet that organizations of all sizes and types can use with a quality improvement/plan-do-study-act approach to reducing a disparity among those you serve. It walks you through how to find a disparity, set some goals, and plan and monitor an intervention to improve the care you're delivering to a particular group of patients. We

encourage you to complete this resource with your team to identify a goal or goals for your team and your program or organization related to reducing disparities. Building the CMS Disparities Impact Statement into your strategic plan and overall goals will embed health equity within your overall quality strategy and help make health equity an explicit priority.

2. To start looking at data to identify disparities, CMS has a [Mapping Medicare Disparities \(MMD\) Tool](#). The MMD tool contains health outcome measures for disease prevalence, costs, hospitalization for 60 specific chronic conditions, emergency department utilization, readmissions rates, mortality, preventable hospitalizations, and preventive services at the state and county levels. You can select your comparison group by selecting different measures in the left panel such as sex, age, race and ethnicity, dual eligible, Medicare eligibility. This will allow you to assess differences between different populations within a county. The [Quick Start Guide](#) is a helpful resource to start playing with the data. There is also the ability to download the data that you are viewing with the Download Data button at the bottom left of the screen. To identify which county(ies) to prioritize, you may consider things such as magnitude of the disparity, common disparities across counties, readiness of counties to address health disparities, etc.
3. To identify possible strategies to address the health disparity(ies) you identified, you can review the CMS [Health Equity Resource Center](#), including this CMS resource titled [Health Equity Challenges and CMS Resources to Help Address Them](#), CMS OMH's [Rural Health Resources page](#), and [Health Equity Webinars](#).

Thank you for your work advancing health equity,

Health Equity Technical Assistance Team

HealthEquityTA@cms.hhs.gov

CMS Office of Minority Health

Visit us at go.cms.gov/healthequityTA



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From: Nichole Jefferson <njefferson@healinghandshealthcare.us>

Sent: Wednesday, December 20, 2023 11:09 AM

To: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>

Subject: Healing Hands Healthcare

Good morning,

We had a scheduled call on 12/12 but on 12/11 I was informed that upon reviewing my request again and the types of TA that I'm interested in, you all think it would be beneficial to send me select resources to review first. I'm following up on that I have not received any resources to review. Can I have an estimated time frame for the materials to come? I have a committee that I need to report to regarding this.



NICHOLAS JEFFERSON, M.D.S. HEALTHCARE LAW,
SSW, BS, MCS-C
DIRECTOR OF COMPLIANCE



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(940) 235-5340



(940) 432-0275



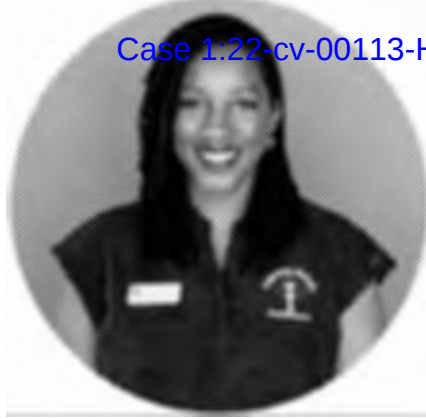
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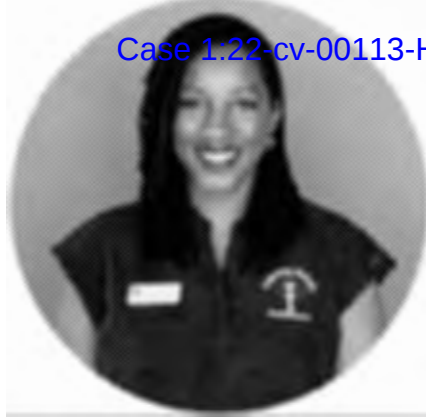
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“Working to Achieve Health Equity”

From: [CMS Health Equity TA](#)
To: [Saumya Khanna \(she/her\); Phoebe Lamuda; Lauren Isaacs](#)
Cc: [Mollie Hertel \(Hertel-Mollie@norc.org\)](#)
Subject: Fw: Health Equity 2022-2023 | CareMax, Inc.
Date: Friday, January 20, 2023 4:58:42 PM
Attachments: [image006.png](#)
[image007.png](#)
[image008.png](#)
[image009.png](#)
[image010.png](#)
[image011.png](#)

Phoebe/Saumya - can you send an invite?

From: Carolina Veira <carolina.veira@caremax.com>
Sent: Friday, January 20, 2023 1:30 PM
To: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>
Subject: RE: Health Equity 2022-2023 | CareMax, Inc.

This is fantastic. Let's meet next Friday 1/27 at 2PM please.

Thank you for your support.

From: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>
Sent: Tuesday, January 17, 2023 1:56 PM
To: Carolina Veira <carolina.veira@caremax.com>
Subject: Re: Health Equity 2022-2023 | CareMax, Inc.

CAUTION: This email originated from outside of the organization. Do not click links or open attachments unless you recognize the sender and know the content is safe.

Dear Carolina,

Thank you for contacting the CMS Health Equity Technical Assistance Team. We are happy to take your comments about advancing the CMS Framework for Health Equity in writing. If you prefer, we are available for a 30-minute technical assistance phone call on 1/27 from 2-3 pm ET or on 2/3 from 1-2:30 pm ET.

The TA we offer is flexible and tailored to whatever questions, ideas, or challenges you've got. Some examples of what we've done for other organizations (e.g.: hospitals, HIINs, health plans, QIN-QIOs, national and local provider associations and groups, and FQHCs and clinics) are:

- Help you draft or improve a strategic plan for your organization to address disparities over a few years with full support of your leadership, board, and staff (e.g.: a 5 year equity plan)
- Help you start thinking about your data and how to identify a particular disparity to focus on
- Help you find possible solutions to address a disparity you've identified – e.g.: an intervention for a particular population, training modules, and other strategies to improve

the ability of your workforce to effectively treat the patients you serve

- Help you draft a CMS Disparities Impact Statement to structure your disparities work using a quality improvement approach and a PDSA cycle
- Help you draft a Language Access Plan to help your organization ensure you are addressing all of your patients' communication needs in a culturally appropriate and competent way
- Help you consider the physical accessibility, equipment, and training of staff in your clinical environment to ensure individuals with physical access challenges are able to get the care they need
- Help you find general or specific (depending on what you need) information, resources, and CMS data to help you address disparities in the population you serve

I've also attached a two-pager that describes a bit more about our TA, how it works and what we offer. We also have a number of resources posted on our Health Equity TA website at go.cms.gov/healthequityTA, which we hope you will find helpful.

Thank you again for emailing – and for your work in helping to address health disparities!

Health Equity Technical Assistance Team

HealthEquityTA@cms.hhs.gov

CMS Office of Minority Health

Visit us at [go.cms.gov/healthequityTA]go.cms.gov/healthequityTA

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From: Carolina Veira <carolina.veira@caremax.com>

Sent: Monday, January 9, 2023 12:38 PM

To: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>

Subject: Health Equity 2022-2023 | CareMax, Inc.

Good afternoon,

Kindly, I would like to reach out to someone in the Office of Minority Health to discuss opportunities where CareMax can collaborate advancing the areas of focus of your framework.

I would also appreciate the opportunity to share more information about CareMax and our impact work with you. There is so much we can do by partnering and working together to advance underrepresented communities locally and nationally.

Looking forward to our first meeting.

Regards,

-Carolina

Carolina M. Veira (She/Her/Ella)

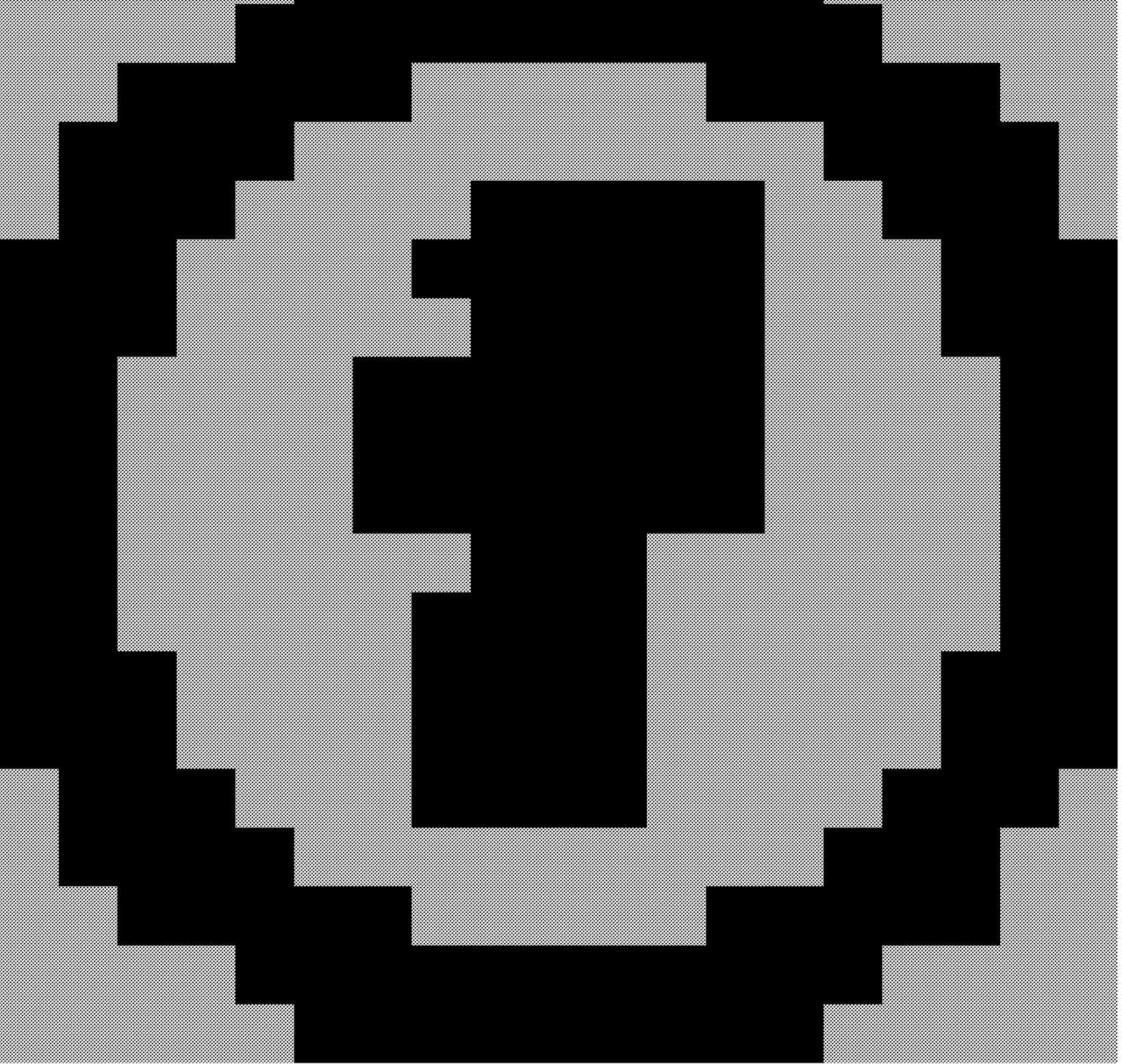
VP, Community & Corporate Partnerships

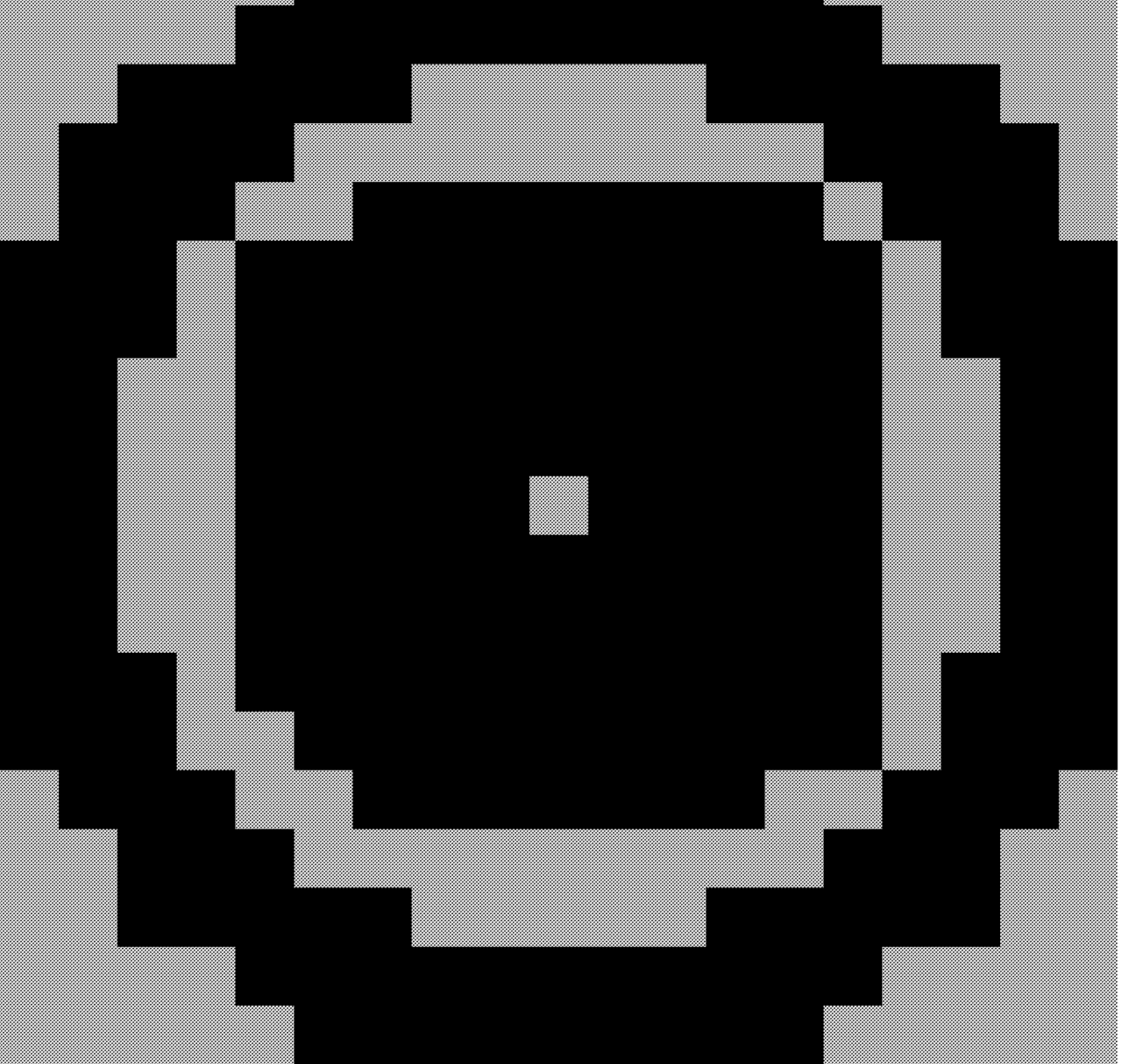
Carolina.Veira@CareMax.com

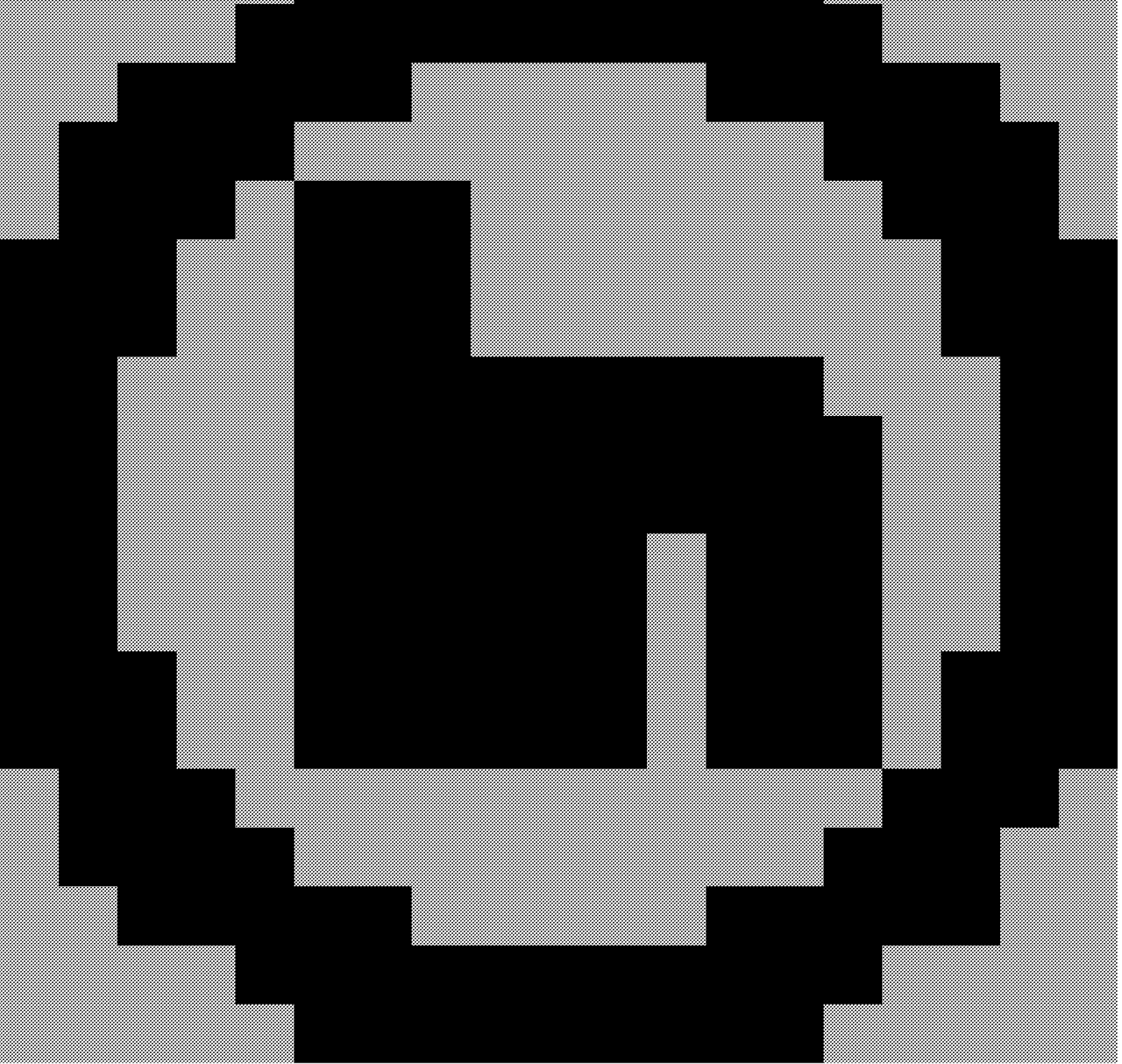
Cell 786.459.3402

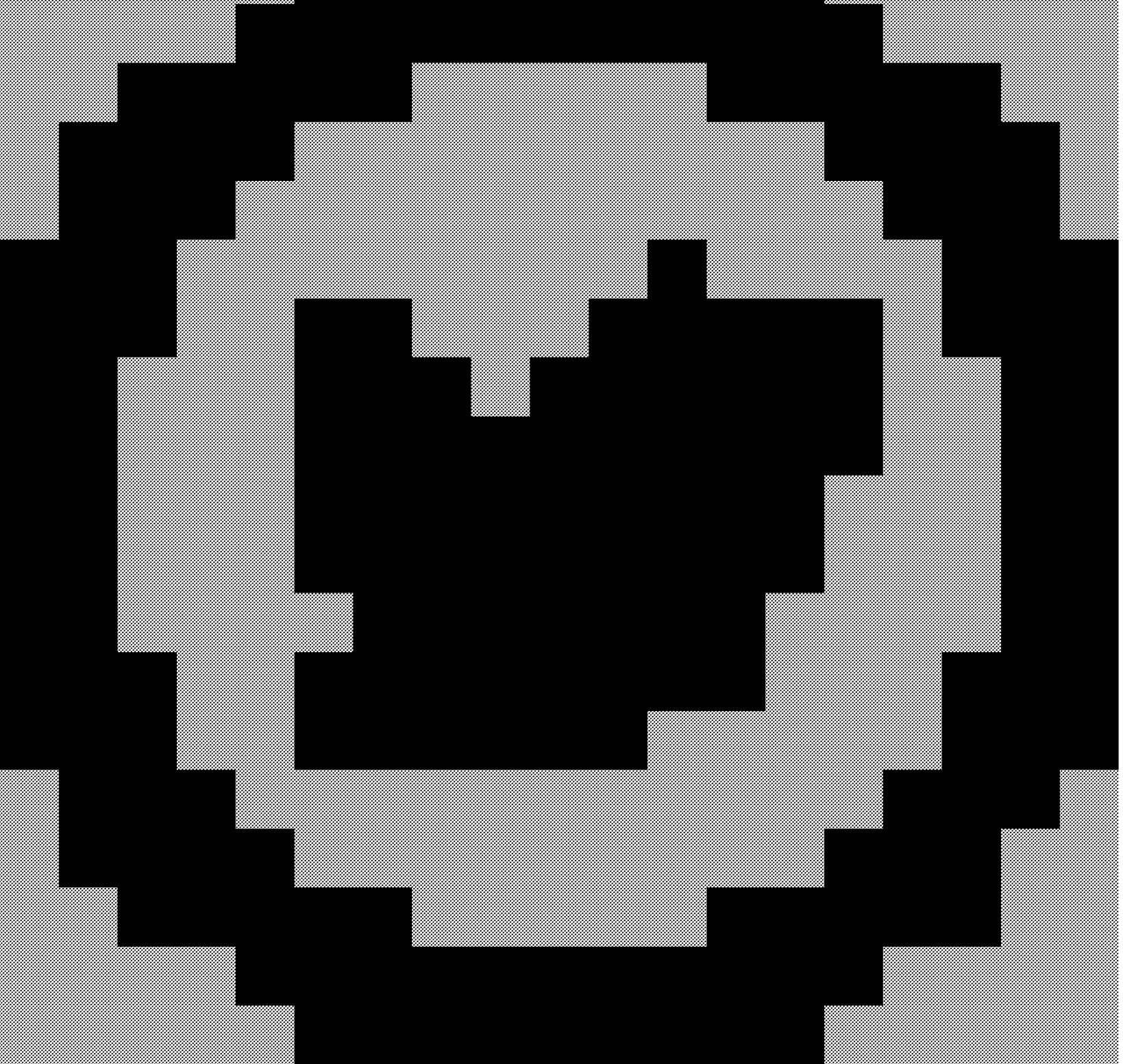
Our Impact

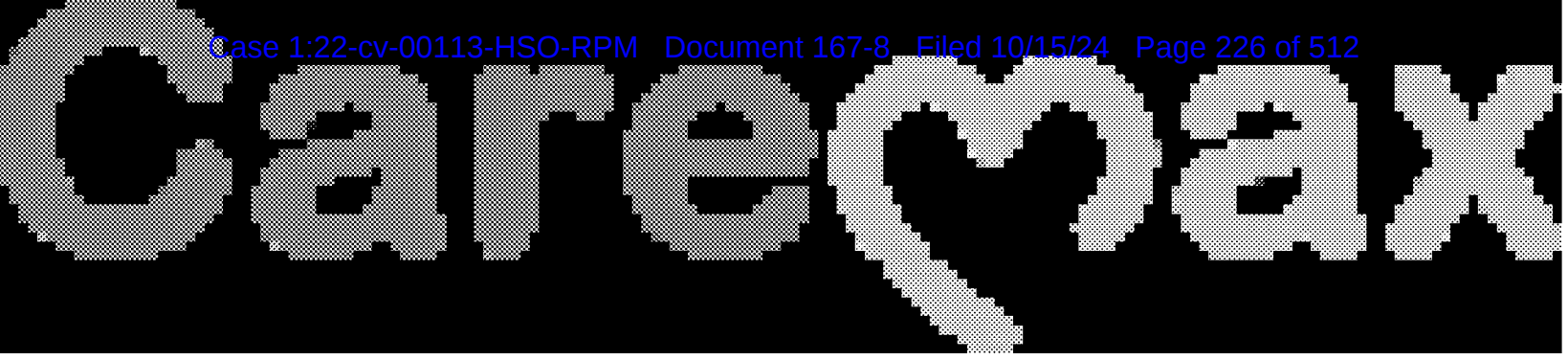












From: CMS Health Equity TA
To: carolina.veira@caremax.com; Bryden, Alexandra (CMS/OMH); Graves, Darci (CMS/OMH); Mollie Hertel (Hertel-Mollie@norc.org); Phoebe Lamuda; Saumya Khanna (she/her)
Cc: Vanessa Fritz; Elizabeth Tavares; Kimberly Anderson; Teresa McMeans
Subject: CareMax/CMS OMH Health Equity TA Call
Start: Wednesday, February 8, 2023 2:00:00 PM
End: Wednesday, February 8, 2023 2:30:00 PM

.....

Dear Carolina,

Thank you for your TA request. We look forward to discussing, alongside the NORC team, the following request:

"Kindly, I would like to reach out to someone in the Office of Minority Health to discuss opportunities where CareMax can collaborate advancing the areas of focus of your framework.

I would also appreciate the opportunity to share more information about CareMax and our impact work with you. There is so much we can do by partnering and working together to advance underrepresented communities locally and nationally."

Join Zoom Meeting

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+1 386 347 5053 US

+1 507 473 4847 US

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81161929794@zoomcrc.com

Quality Payment Program Service Center

Cases related to IA_AHE_8 "Create and Implement an Anti-Racism Plan"

Case Number	Inquiry	Response
CS1589446	We had a clinician ask yesterday about whether IA_AHE_8, Create and Implement an Anti-Racism Plan, would be acceptable for non-patient facing clinicians. Would this IA be allowable for non-patient facing clinicians, provided they participate in a meaningful way and have proper documentation? Thank you for your assistance!	<p>Thank you for reaching out to the Quality Payment Program Service Center regarding We had a clinician ask yesterday about whether IA_AHE_8, Create and Implement an Anti-Racism Plan, would be acceptable for non-patient facing clinicians. All Improvement activities Measures can be reported by anyone unless specifically stated in the Measure Specification.</p> <p>All measure specifications can be found by going to qpp.cms.gov and under the MIPS tab click on Explore Measures & Activities. Scroll down clicking on the correct Performance Year which would be the 2022 and Improvement Activities. Now under the Subcategory Name click on the Achieving Health Equity. Now look for your measure.</p> <p>The state of this case CS1589446 is being updated to awaiting. We will close this case if you can confirm case resolution, please call us back, otherwise, please let me know how we can provide further assistance by Friday March 18th, 2022.</p> <p>Closing Notes: Thank you for reaching out to the Quality Payment Program Service Center regarding We had a clinician ask yesterday about whether IA_AHE_8, Create and Implement an Anti-Racism Plan, would be acceptable for non-patient facing clinicians.</p> <p>I am glad I could help. I appreciate the opportunity to assist you.</p> <p>The status of ticket CS1589446 has been updated to resolved as all necessary actions have been completed.</p> <p>Please reach out to us at the Service Center if additional support is needed.</p>

CS1924777	Customer is wanting to know what she needs to do to get started for reporting.	<p>Thank you for contacting the QPP Service Center, it was a pleasure assisting you today! During our call we went over Eligibility, Henry is a MIPS eligible Clinician for 2023 Reporting Year, With Special Statuses of: Health Professional Shortage Area (HPSA), Rural and Small practice</p> <p>For all of these you will earn 2x the points for each improvement activity you submit when reporting traditional MIPS and you will receive a reweighting for the Promoting Interoperability Category, (meaning you will not have to report that category)</p> <ul style="list-style-type: none"> • <u>For Quality:</u> You will need to report on 6 measures; one of them being an Outcome Measure or High Priority Measure. We went to the MIPS tab, then to the Explore Measures and Activities tool. We went over how to filter to find measures you can use. We explored Measure 130, (this is a High Priority Measure) Documentation of Current Medications in the Medical Record and reviewed the measure Specification, and Measure 117: Diabetes: Eye Exam and reviewed the Specifications. • <u>For Improvement Activities:</u> You will need to report either 2 Medium weighted or 1 High weighted Activity. We went to the MIPS tab, then to the Explore Measures and Activities tool. We went over how to filter to find Activities you can use. We explored Activity IA_AHE_8: Create and Implement an Anti-Racism Plan. This is a high weighted Activity and will fulfill your reporting requirements for the Improvement Activities Category. <p>To create your Account, please visit HARP.CMS.Gov and select Sign Up. Please contact us again if additional support is needed.</p>
CS1648923	Please send information for increased payments to physicians who have an anti-racism program present within the medical office. Thank you. George Flinn, MDwhbq@aol.com	<p>Thank you for contacting the QPP Service Center, it has been a pleasure assisting you!</p> <p>Please see our response regarding your inquiry below:</p> <p>By completing this activity, it does not grant a 9% incentive. IA_AHE_8 - Create and Implement an Anti-Racism Plan is an available activity that may be completed by a MIPS eligible clinician. Through the MIPS program, if eligible, the clinicians may earn up to a positive or negative 9% payment adjustment based on how they performed for the entire program as the Improvement Activities is only one category of the program.</p>

		<p>You can learn more about this activity and it's requirements here: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1780/2022%20MIPS%20Data%20Validation%20Criteria.zip</p> <p>If you have more specific questions related to the activity itself, please respond with your follow up questions and we will be happy to assist.</p> <p>Please note this case will be resolved at this time.</p> <p>If you have further questions, please contact the Quality Payment Program Service Center via phone at 1-866-288-8292 Monday through Friday 8:00 am-8:00 pm EST or via e-mail at qpp@cms.hhs.gov.</p> <p>If you have not already subscribed, consider signing up for the QPP Listserv. With this, you will be kept informed of all the latest information from CMS regarding QPP. You can sign up by visiting the website qpp.cms.gov, and on the homepage, scrolling to the bottom and entering your email into the Subscribe to Updates box and clicking the Subscribe button.</p>
CS2117997	Xhulia is calling in today requesting additional information regarding the MIPS program. Account registration required as well.	<p>Thank you for contacting the CCSQ Service Center, it was a pleasure assisting you today! During our call we went over traditional MIPS Requirements for Quality and Improvement Activities, Special Status. Your Practice has a special Status of small Practice and will not need to report PI and for Improvement Activities each Activity you report is worth double points.</p> <ul style="list-style-type: none"> • <u>Quality Reporting</u> - You'll need to submit collected data for at least 6 quality measures (including one outcome measure or high priority measure in the absence of an applicable outcome measure), or a complete specialty measure set. You'll need to report performance data for at least 70% of the denominator eligible cases for each quality measure (data completeness). <p>We went over some Quality Measures, Your Outcome Measure has a * next to it:</p> <ul style="list-style-type: none"> ○ Quality ID: 370 - Depression Remission at Twelve Months ○ Quality ID: 130 - Documentation of Current Medications in the Medical Record

		<ul style="list-style-type: none"> ○ Quality ID: 134 - Preventive Care and Screening: Screening for Depression and Follow-Up Plan ○ Quality ID: 226 - Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention ○ Quality ID: 047 - Advance Care Plan ○ Quality ID: 487 - Screening for Social Drivers of Health ○ Quality ID: 374 - Closing the Referral Loop: Receipt of Specialist Report <ul style="list-style-type: none"> • For Improvement Activities - we looked at 1 High Weighted Activity, this will fulfill the Improvement Activity Requirements: <ul style="list-style-type: none"> ▪ Activity ID: IA_AHE_8: Create and Implement an Anti-Racism Plan Data will not need to be collected or submitted, you will need to attest for the 90 days that the Activity was done and that yes you did it. ○ Cost - is automatically factored, you will not need to collect or report data. <p>Please contact us again if additional support is needed.</p>
CS1366613	<p>Would you please provide some preliminary guidelines on what documentation would be required to satisfy the intent of the following improvement new activities, which are being proposed for the 2022 performance year?</p> <ul style="list-style-type: none"> ○ IA_AHE_xx Create and Implement an Anti-Racism Plan ○ IA_BMH_xx Promoting Clinician Well-Being ○ IA_ERP_xx Implementation of a Personal Protective Equipment (PPE) Plan 	<p>Thank you for contacting the QPP Service Center and working with us on some preliminary guidelines on what documentation would be required to satisfy the intent of the new Improvement Activities.</p> <p>We do not have the Improvement Activities Specifications available for 2022 reporting. This will be available in late fall.</p> <p>Make sure you are signed up to receive the most up-to-date information as it relates to QPP, sign-up to receive listserv messages. Visit https://qpp.cms.gov, scroll to the bottom of any page and select "Subscribe to Email Updates." There will be an option to register for Quality Payment Program</p> <p>The status of ticket CS1366613 has been updated to resolved as all necessary actions have been completed.</p> <p>Please reach out to us at the Service Center if additional support is needed.</p>

CS1532573	<p>Can you please provide the criteria that must be met in order to receive MIPS payments for Improvement Activity IA_AHE_8: Achieving Health Equity under Final Rule: Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; and Provider and Supplier Prepayment and Post-Payment Medical Review Requirements.</p>	<p>The 2022 MIPS Data Validation and Audit Criteria outline the Activity description, as well as Objectives/requirements and suggested validation documentation which can be found here: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1780/2022%20MIPS%20Data%20Validation%20Criteria.zip</p> <p>We recommend reviewing the '2022 Improvement Activities Criteria' PDF specifically. Please let me know after reviewing if you have any further questions as it relates to this activity.</p> <p>With the MIPS program, clinicians are determined to be eligible or exempt based on the eligibility requirements. If a clinician is eligible to report and reports data, they will attest to the completed Improvement Activities of their choice during the data submission time frame, and or upload a file to the QPP portal to indicate the Improvement Activities you are attesting to.</p> <p>With regard to your second question, 'And does the anti-racism plan have to be in effect for 90 days before they can apply for payment under this new activity?', the Improvement Activities performance category has a 90 day minimum requirement, meaning in order for the clinician to attest to completing this activity at the time of data submission, the clinician would have had to have completed the activity (based on the requirements outlined in the data validation criteria), for a minimum of 90 consecutive days.</p> <p>There is not a specific form that is to be completed for the attestation. At the time of data submission, the submitter would simply log into the QPP portal, and then select the Improvement Activity they are wishing to attest to. There is no additional information, or any other forms of paperwork necessary to complete submission. However, it is encouraged to go by the suggested documentation within the Data Validation and Audit Criteria to retain for your own records in the event of an audit. You can learn more about the Data Submission process here: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1731/2021%20Data%20Submission%20FAQs.pdf</p>
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		<p>Please note this case will be resolved at this time.</p> <p>If you have further questions, please contact the Quality Payment Program Service Center via phone at 1-866-288-8292 Monday through Friday 8:00 am-8:00 pm EST or via e-mail at qpp@cms.hhs.gov.</p> <p>If you have not already subscribed, consider signing up for the QPP Listserv. With this, you will be kept informed of all the latest information from CMS regarding QPP. You can sign up by visiting the website qpp.cms.gov, and on the homepage, scrolling to the bottom and entering your email into the Subscribe to Updates box and clicking the Subscribe button.</p> <p>Thank you for contacting the QPP Service Center, it has been a pleasure assisting you!</p>

QUALITY PAYMENT PROGRAM (QPP) 2022 PARTICIPATION AND PERFORMANCE RESULTS AT-A-GLANCE

The QPP Participation and Performance Results At-a-Glance provides an overview of QPP participation, MIPS final performance scores, and payment adjustments. Two important points to highlight are:

- The cost category is included in the final score calculation for the first time since the 2019 performance year.
- The 2022 performance year is the final year for the exceptional performance adjustment.

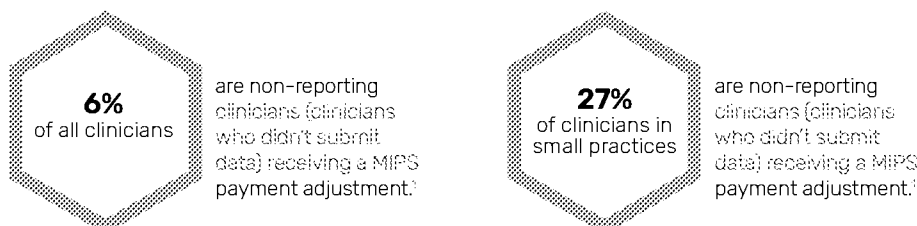
For more information about key terms and data included in this resource, refer to the [2022 QPP Data Use Guide](#).

QPP Participation and Performance in the 2022 Performance Year

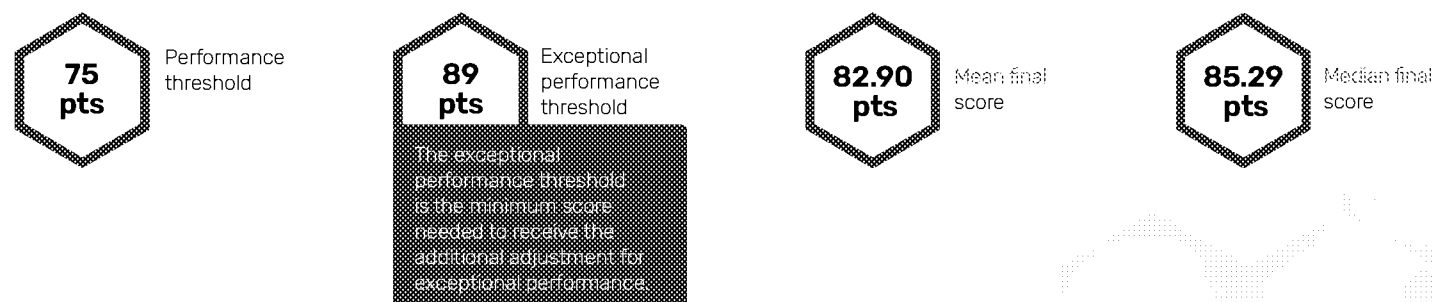
1. General Participation Numbers in 2022



2. Non-Reporting Clinician Rates (Overall and Small Practices)



3. Final Score Information



While clinicians were allowed to submit a MIPS Extreme and Uncontrollable Circumstances (EUC) Exception application due to COVID-19, this exception wasn't automatically applied to all MIPS eligible clinicians for 2022.

Clinicians were also scored on the cost performance category for the first time in 3 years. When coupled with other changes to scoring policies effective in 2022, such as the removal of quality bonus points, changes to performance category weights, and changes to the complex patient bonus methodology, mean and median final scores were lower than in previous years.

¹ A non-reporting clinician is an individually eligible clinician who didn't actively submit any data for the quality, promoting interoperability, or improvement activities performance category. Because they're individually eligible, they will receive a final score and MIPS payment adjustment even if no data was actively submitted.

² For more information, refer to [section 11 on page 6](#), the [2022 QPP Data Use Guide](#), and the [QPP website](#).



4. Payment Adjustment Highlights for MIPS Eligible Clinicians

PAYMENT ADJUSTMENT TYPE	Max Negative*	Negative*	Neutral	Positive Only	Exceptional**
Payment Adjustment Range	-9%	-6.75% - 0%	0%	0% - 1.25%	1.55% - 8.26%
Associated Final Score Range	0 - 18.75 points	18.76 - 74.99 points	75 points	75.01 - 88.99 points	89 - 100 points
Percentage of MIPS Eligible Clinicians in Payment Adjustment/ Final Score Range	2%	12%	7%	37%	42%
Base Adjustment (1.25% - 2.24%) + Exceptional Adjustment (0.30% - 6.02%)					

MIPS is required by law to be a budget neutral program, which generally means that the projected negative adjustments must be balanced by the projected positive adjustments. When more clinicians receive a negative payment adjustment, clinicians with a positive payment adjustment see a larger payment adjustment amount. You can learn more in the [2024 MIPS Payment Year Payment Adjustment User Guide \(PDF\)](#).

***Max Negative vs. Negative:** Statute mandates that clinicians scoring in the bottom quartile below the performance threshold receive the maximum negative payment adjustment (-9%, starting with the 2020 performance year). The remainder of clinicians who score below the performance threshold will receive a negative payment adjustment on a sliding scale.

****Exceptional:** Clinicians in the "Exceptional" range are actually receiving 2 payment adjustments — the base MIPS payment adjustment and the additional adjustment for exceptional performance. The remainder of clinicians who score above the performance threshold but below the exceptional threshold will only receive a base payment adjustment. Positive MIPS payment adjustments are higher this year than in past years for 2 reasons:

- 1) More clinicians earned a final score below the performance threshold (75 points), resulting in higher base adjustments than in past years.
- 2) Fewer clinicians earned a final score at or above the exceptional performance threshold (89 points), resulting in higher exceptional adjustments than in past years.

The 2022 performance year is the final year for the exceptional performance adjustment, which will be paid in the 2024 MIPS payment year.



5. Final Scores by Participation Option

Participation option refers to the level at which data is collected and submitted to MIPS. Learn more about [MIPS participation options](#).

Participation Option	Mean Final Score	Median Final Score
Individual (46,242 MIPS eligible clinicians)	55.65	75.00
Group (427,425 MIPS eligible clinicians)	82.00	81.41
Virtual Group (94 MIPS eligible clinicians)	90.20	94.02
APM Entity (150,448 MIPS eligible clinicians)	93.81	93.95

The **mean is the average** value of a set of numbers, while the **median is the middle value** in a set of numbers. Refer to the [2022 Data Use Guide](#) for additional examples.

An Alternative Payment Model (APM) is a payment approach that gives added incentive payments to provide high-quality and cost-efficient care. An **APM Entity** is an organization that participates in one of these models. A Medicare Shared Savings Program Accountable Care Organization (ACO) is an example of an APM Entity.

To be included in this table, the APM Entity must participate in a specific kind of APM called a [MIPS APM](#) and include MIPS eligible clinicians.

6. Mean and Median Unweighted Scores for Each Performance Category

The unweighted score (0 – 100%) is generally determined by dividing *the points earned* by *the points available* in a performance category. For example: Earning 20 out of 40 points for the improvement activities would result in an unweighted score of 50%. This is the measure of true performance, before it's multiplied by the category's weight to determine how many points will contribute to the final score. For example: An unweighted quality score of 100% is worth 30 points when the category is weighted at 30% of the final score.

	Mean Unweighted Category Score	Median Unweighted Category Score
Quality	74.63%	78.40%
Cost	59.70%	59.02%
Promoting Interoperability	94.94%	100.00%
Improvement Activities	95.96%	100.00%



7. Snapshot of 2024 Payment Adjustments for Small, Solo, and Rural Practices

		Max Negative	Negative	Neutral	Positive Only	Exceptional
Percentage of MIPS Eligible Clinicians	All	2.09%	11.48%	7.17%	37.04%	42.22%
Percentage of Small Practices	Overall	12.59%	14.34%	17.41%	20.72%	34.93%
	Non-reporting*	42.63%	12.72%	44.65%	0.00%	0.07%
Percentage of Solo Practitioners	Overall	27.53%	17.95%	22.45%	10.23%	21.84%
	Non-reporting*	50.83%	15.98%	33.19%	0.00%	0.00%
Percentage of Rural Practices	Overall	2.18%	15.70%	7.40%	36.66%	38.06%
	Non-reporting*	34.07%	11.91%	54.02%	0.00%	0.00%

*A non-reporting clinician refers to an individually eligible clinician who didn't actively submit any data for the quality, Promoting Interoperability, or improvement activities performance categories. Because they're individually eligible, they'll receive a final score and MIPS payment adjustment even if no data was actively submitted. Their final score can include data calculated and scored automatically by CMS, such as administrative claims-based quality measures or cost measures.

QPP Participation and Performance Changes from Previous Years³

This section compares information between the 2019, 2021, and 2022 performance years. We are including 2019 as a point of comparison, as it predates the COVID-19 Public Health Emergency (PHE). We're excluding data from the 2020 performance year as this was the first performance year of the PHE.

8. MIPS Participation Changes

The drop in the number of MIPS eligible clinicians occurred between the 2020 and 2021 performance years, as a result of policy changes specific to MIPS APM participation. Learn more about these changes in the [2021 Experience Report](#).

	2019	2021	Change (percent) from 2019 to 2021	2022	Change (percent) from 2021 to 2022
Total clinicians receiving a MIPS payment adjustment (positive, neutral, or negative)	957,462	698,883	↓ 27.01%	624,209	↓ 10.68%

³ Prior years' data may not match the data included in the associated year's experience report due to the timing of when that data was pulled.



9. Final Score Changes

There are several program changes in the 2022 performance year that contributed to lower final scores overall:

- The calculation of the cost performance category for the first time since the 2019 performance year, along with an expanded number of cost measures that could be attributed to clinicians.
- Changes to performance category weights, and a wider variety of weights applied.
- The removal of quality measure bonus points.
- A change in the complex patient bonus methodology, resulting in fewer clinicians being eligible for this bonus.

	2019	2021	2022
Mean Final Score	85.65	89.22	82.90
Median Final score	92.32	97.22	85.29

10. MIPS Eligible Clinicians: Payment Adjustment Changes

This table shows changes to the percentage of MIPS eligible clinicians in each of the 5 payment adjustment ranges. This data includes all MIPS eligible clinicians receiving a payment adjustment, regardless of data submission. The previously noted reasons for a decrease in final scores along with increased performance thresholds affected the distribution of clinicians receiving each payment adjustment range. For example, clinicians needed a final score of 89 points in 2022 to earn an Exceptional adjustment, an increase from 85 points in 2021. Similarly, they needed a final score of 75 points in 2022 to avoid a negative adjustment, an increase from 60 points in 2021. Although there has been a considerable decrease in the number of clinicians receiving an Exceptional adjustment in 2022, there has also been a significant increase in the number of clinicians who are receiving a Positive Only adjustment. Overall, almost 80% of clinicians will receive a positive adjustment based on their 2022 performance.

	2019	2021	2022
Exceptional (75 points or higher)	83.89%	77.86%	42.22%
Positive Only (30.01 – 74.99 points)	11.46%	8.26%	37.04%
Neutral (30 points)	4.36%	10.57%	7.17%
Negative (7.51 – 29.99 points)	0.28%	2.27%	11.48%
Max Negative (0 – 7.5 points)	0.01%	1.04%	2.09%



11. Qualifying APM Participation Changes

This table shows the changes in the number of clinicians achieving QP and Partial QP status based on their Advanced APM Participation. The statuses are determined by the volume of patients seen and payments received by the clinician through the APM Entity.

- QPs receive at least **50%** of Medicare Part B payments OR see at least **35%** of Medicare patients through an Advanced APM Entity. They're exempt from MIPS. They aren't eligible to receive a MIPS payment adjustment but will receive a financial incentive for being a QP.
- Partial QPs receive at least **40%** of Medicare Part B payments OR sees at least **25%** of Medicare patients through an Advanced APM Entity. They can choose whether to participate in MIPS. If they elect to participate, they'll receive a MIPS payment adjustment. Partial QPs aren't eligible for QP incentives.

	2019	2021	2022
Total number of Advanced APM participants	279,900	333,658	420,591
Total number of QPs	209,379	273,819	386,263
Total number of Partial QPs	14,180	835	370

Where Can I Learn More?

The [2022 QPP Participation and Performance Results At-a-Glance](#) is intended to provide you with a snapshot of QPP participation and performance in the 2022 performance year.

The [2022 QPP Experience Report](#) provides a more in-depth review of aggregated data on QPP program experience for the 2022 performance year, including a review of program trends over time.

The [2022 QPP Public Use File](#) provides detailed, clinician-level data regarding eligibility, measure level scoring, performance category scoring, final scores, and payment adjustments.

The companion [2022 QPP Data Use Guide](#) (along with the [2022 QPP PUF Data Dictionary](#) and [2022 QPP PUF Methodology](#)) provides information about key terms and data included in these resources.



From: [Adams, Laura](#)
To: [CMS Health Equity TA](#)
Cc: [Mitchen, Karen](#)
Subject: RE: *EXTERNAL* Re: Support With Addressing Health Equity
Date: Wednesday, January 10, 2024 10:16:07 AM
Attachments: [image001.png](#)

Thanks! We appreciate the additional resources.

Best Regards,

Laura

Laura Adams, MBA

Director, Medicare Stars

Medical Mutual

1-216-687-6845

Laura.Adams@MedMutual.com

From: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>
Sent: Wednesday, January 10, 2024 9:27 AM
To: Adams, Laura <Laura.Adams@medmutual.com>
Cc: Mitchen, Karen <Karen.Mitchen@medmutual.com>
Subject: *EXTERNAL* Re: Support With Addressing Health Equity

Caution: This message was sent from an external source, be cautious when clicking links and/or responding to this email with sensitive information.

Dear Laura,

Thank you for reaching out to the CMS Health Equity Technical Assistance mailbox. Here are some resources you may find helpful:

1. [Health Equity Challenges and CMS Resources to Help Address Them \[cms.gov\]](#): This infographic outlines various barriers to health equity and related challenges that populations often face and shares CMS resources that can help close the health equity gap.
2. The [CMS Disparities Impact Statement \[cms.gov\]](#) worksheet is a straightforward step-by-step

worksheet that organizations of all sizes and types can use with a quality improvement/plan-do-study-act approach to reducing a disparity among those you serve. It walks you through how to find a disparity, set some goals, and plan and monitor an intervention to improve the care you're delivering to a particular group of patients. We encourage you to complete this resource with your team to identify a goal or goals for your team and your program or organization related to reducing disparities.

3. [HHS Healthy People 2030 evidence-based resources \[health.gov\]](#): Allows you to search for interventions/initiatives based on topic and/or population.
4. [CDC's Paving the Road to Health Equity webpage \[cdc.gov\]](#): has some resources on programs and measurement.

Thank you for your work advancing health equity,

Health Equity Technical Assistance Team

HealthEquityTA@cms.hhs.gov

CMS Office of Minority Health

Visit us at go.cms.gov/healthequityTA [go.cms.gov]



"Working to Achieve Health Equity"

NOTE: This communication and any attachment may contain information which is confidential and/or privileged. This information is intended for use only by the addressee(s) indicated above. If you are not the intended recipient, please be advised that any disclosure, copying, distribution, or use of the contents of this information is strictly prohibited. If you have received this communication in error, please notify the sender immediately and delete/destroy all copies of the original transmission.

From: Adams, Laura <Laura.Adams@medmutual.com>

Sent: Thursday, December 14, 2023 9:23 AM

To: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>

Cc: Mitchen, Karen <Karen.Mitchen@medmutual.com>

Subject: Support With Addressing Health Equity

Good morning, I recently read that the CMS OMH Health Equity Technical Assistance Program has services to support MAOs in implementing strategies to address health equity. We have been working on addressing health equity within our MA contracts and wondered if there are any resources that you can direct us to? Some of the areas we are interested in are measurement of

health equity, how to identify appropriate initiatives and how to evaluate the success of implemented initiatives. Any resources you can point us to would be helpful.

Best Regards,

Laura

Laura Adams, MBA

Director, Medicare Stars

Medical Mutual

1-216-687-6845

Laura.Adams@MedMutual.com

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Thank you, Medical Mutual.



“Working to Achieve Health Equity”

From: [CMS Health Equity TA](#)
To: [Victoria McHugh -MDH-](#)
Subject: Re: Disparities Impact Statement Assistance
Date: Wednesday, December 14, 2022 6:07:45 PM
Attachments: [changingMD.png](#)
[image.png](#)

Dear Vickie,

Thank you for contacting the CMS Health Equity Technical Assistance Team. Based on your question about how your improvement goals can meet the Joint Commission's standards, we wanted to be sure you have seen the page for the [Health Care Equity Accreditation Standards & Resource Center](#) and [New and Revised Requirements to Reduce Health Care Disparities](#) (effective January 1, 2023). For specific questions, including about standards, you can contact the Joint Commission using this page: <https://www.jointcommission.org/contact-us/>.

If you have questions about the [CMS Disparities Impact Statement](#), please let us know.

Disparities Impact Statement - Centers for Medicare & Medicaid Services

STEP 2: Define your goals Using the information from STEP 1, set out what you aim to do, by when, and with whom. For example: Implement a Language Access Plan for patients with limited English proficiency.

www.cms.gov

Contact Us | The Joint Commission

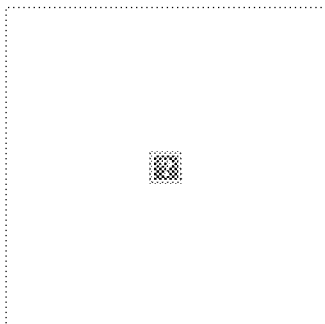
Contact The Joint Commission with questions, customer service, general support or technical support matters.

www.jointcommission.org

New and Revised Requirements to Reduce Health Care Disparities

Effective January 1, 2023, new and revised requirements to reduce health care disparities will apply to Joint Commission–accredited ambulatory health care organizations, behavioral health and human services organizations, critical access hospitals, and hospitals.

www.jointcommission.org



Health Care Equity Accreditation Standards & Resource Center

Our new health care equity resource center is designed to help organizations prepare to meet the Joint Commission's new health care equity standards.

www.jointcommission.org

Thank you for your work advancing health equity.

Sincerely,

Health Equity Technical Assistance Team

HealthEquityTA@cms.hhs.gov

CMS Office of Minority Health

Visit us at [\[go.cms.gov/healthequityTA\]](https://go.cms.gov/healthequityTA)go.cms.gov/healthequityTA



"Working to Achieve Health Equity"

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From: Victoria McHugh -MDH- <victoria.mchugh@maryland.gov>

Sent: Tuesday, December 6, 2022 9:09 AM

To: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>

Subject: Disparities Impact Statement Assistance

Hi,

I am currently working with Springfield Hospital Center to improve and establish Health Equity. My current focus is to create Disparities Impact Statements on some of the equity initiatives at the hospital.

I am working off of the 5 step worksheet, and want to be sure we are meeting TJC standards for each improvement goal. Would you all be able to assist me with this process?

We are looking at some of the disparities and inequities for our patients with Limited English Proficiency, BMI/Diabetes Type 2, Homelessness, and possibly women's health access and limitations in State Psychiatric Hospitals.

Appreciate any help and feedback.

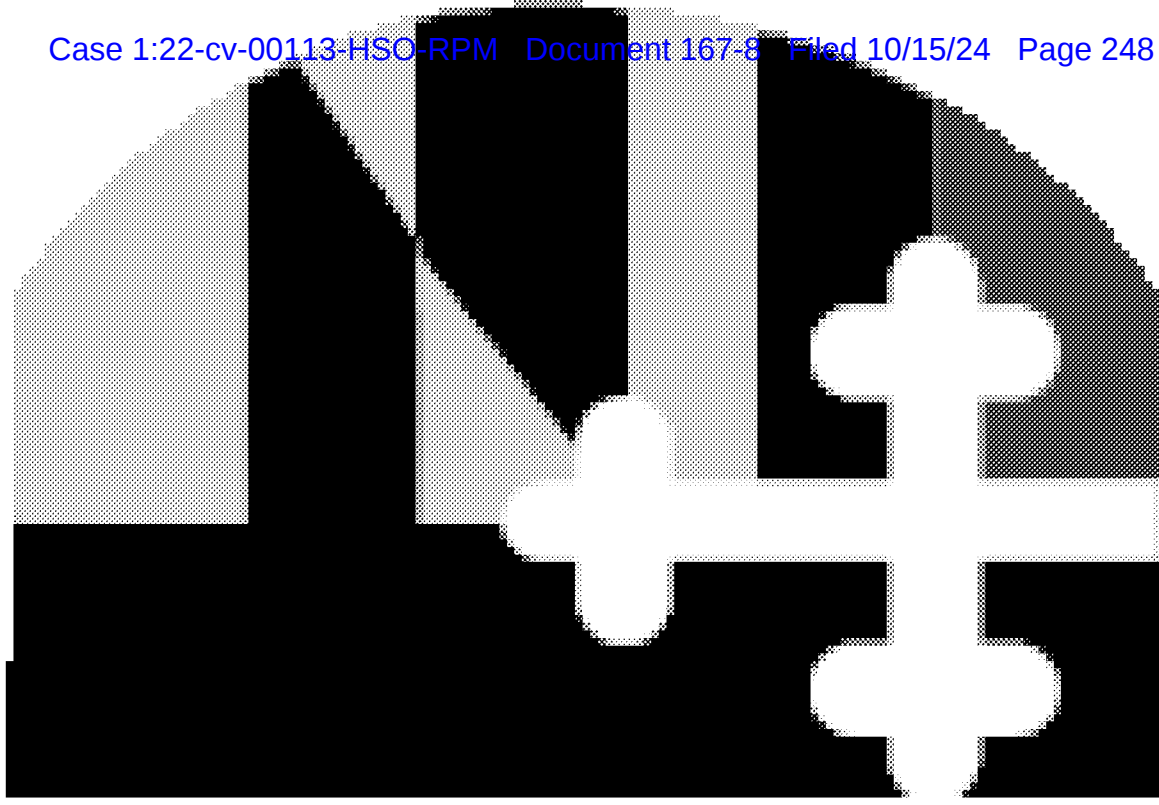
Thanks,

--



Vickie McHugh
Special Projects Manager
Springfield Hospital Center
6655 Sykesville Road
Sykesville, MD 21784
Victoria.McHugh@mayland.gov

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CHANGING

Maryland

for the Better



“Working to Achieve Health Equity”

From: [CMS Health Equity TA](#)
To: [Nicholas Baron](#)
Subject: Re: Disparities Impact Statement
Date: Friday, July 14, 2023 5:06:07 PM
Attachments: [image001.png](#)
[image.png](#)

Dear Nicholas,

Thank you for reaching out to the CMS Health Equity Technical Assistance team. Unfortunately, we are unable to share examples of completed CMS impact statements. There are many organizations that post information online and we encourage you to explore examples that may be relevant to you in your context.

You may have already seen CMS' [Disparities Impact Statement \(DIS\) resource](#) and if you're looking for additional information and guidance please see the following resources:

- [HHS OMH Disparity Impact Strategy](#): provides an overview of HHS OMH's strategy and guidance for grantees to complete a DIS.
- [ASPE In-depth equity assessment guide](#): This tool describes how to conduct intensive equity assessments of existing programs, policies, and processes. It is not identical to the DIS but follows a similar process and may be another useful way to think about your health disparities statement.
 - <https://aspe.hhs.gov/reports/equity-assessment-tip-sheet>: This provides tips on completing each of the 6 steps of the equity assessment.

Thank you for your work advancing health equity,

Health Equity Technical Assistance Team

HealthEquityTA@cms.hhs.gov

CMS Office of Minority Health

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From: Nicholas Baron <NBaron@primary-health.net>
Sent: Monday, July 3, 2023 9:06 AM
To: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>
Subject: Disparities Impact Statement

Can you share some examples of completed impact statements? Thanks! Nick

Nick Baron, MPH FACHE (He/Him)

Director of Operations Quality Control

Operations

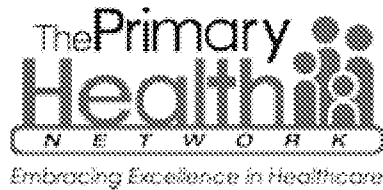
63 Pitt Street

Sharon, PA 16146

Cell: (724) 977-5748

Office: (724) 342-3002

Fax: (724) 704-7390







“Working to Achieve Health Equity”

From: [CMS Health Equity TA](#)
To: [Johns, Louise J.](#)
Subject: Re: Disparities Impact Statement
Date: Thursday, October 20, 2022 4:56:55 PM
Attachments: [Technical Assistance.pdf](#)
[Outlook-illgotbg.png](#)

Dear Louise,

Thank you for contacting the CMS Health Equity Technical Assistance Program. The TA we offer is flexible and tailored to whatever questions, ideas, or challenges you've got. Some examples of what we've done for other organizations (e.g.: hospitals, HIINs, health plans, QIN-QIOs, national and local provider associations and groups, and FQHCs and clinics) are:

- Help you draft or improve a strategic plan for your organization to address disparities over a few years with full support of your leadership, board, and staff (e.g.: a 5 year equity plan)
- Help you start thinking about your data and how to identify a particular disparity to focus on
- Help you find possible solutions to address a disparity you've identified – e.g.: an intervention for a particular population, training modules, and other strategies to improve the ability of your workforce to effectively treat the patients you serve
- Help you draft a CMS Disparities Impact Statement to structure your disparities work using a quality improvement approach and a PDSA cycle
- Help you draft a Language Access Plan to help your organization ensure you are addressing all of your patients' communication needs in a culturally appropriate and competent way
- Help you consider the physical accessibility, equipment, and training of staff in your clinical environment to ensure individuals with physical access challenges are able to get the care they need
- Help you find general or specific (depending on what you need) information, resources, and CMS data to help you address disparities in the population you serve

The first step is usually that we'd set up a time to talk with you for 30 minutes about what you're thinking of, so if you're interested in chatting please let us know and share a few dates/times that might work in your schedule.

I've also attached a two-pager that describes a bit more about our TA, how it works and what we offer. We also have a number of resources posted on our Health Equity TA website at go.cms.gov/healthequityTA, which we hope you will find helpful.

Thank you again for emailing – and for your work in helping to address health disparities.

We look forward to working with you,

Health Equity Technical Assistance Team

HealthEquityTA@cms.hhs.gov

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From: Johns, Louise J. <ljjohns@archbold.org>

Sent: Thursday, October 6, 2022 12:20 PM

To: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>

Subject: Disparities Impact Statement

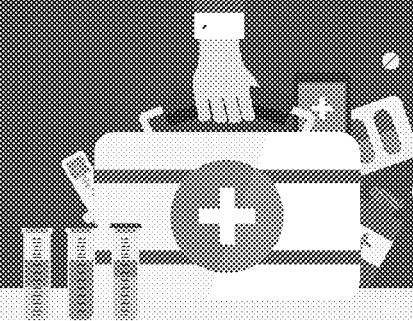
What assistance can you provide for completing Disparities Impact Statement?

Louise Johns RN, MSN
Director of Quality
Archbold Memorial Hospital
Gordon Avenue at Mimosa Drive
Thomasville, GA 31792
229-228-8452
www.archbold.org



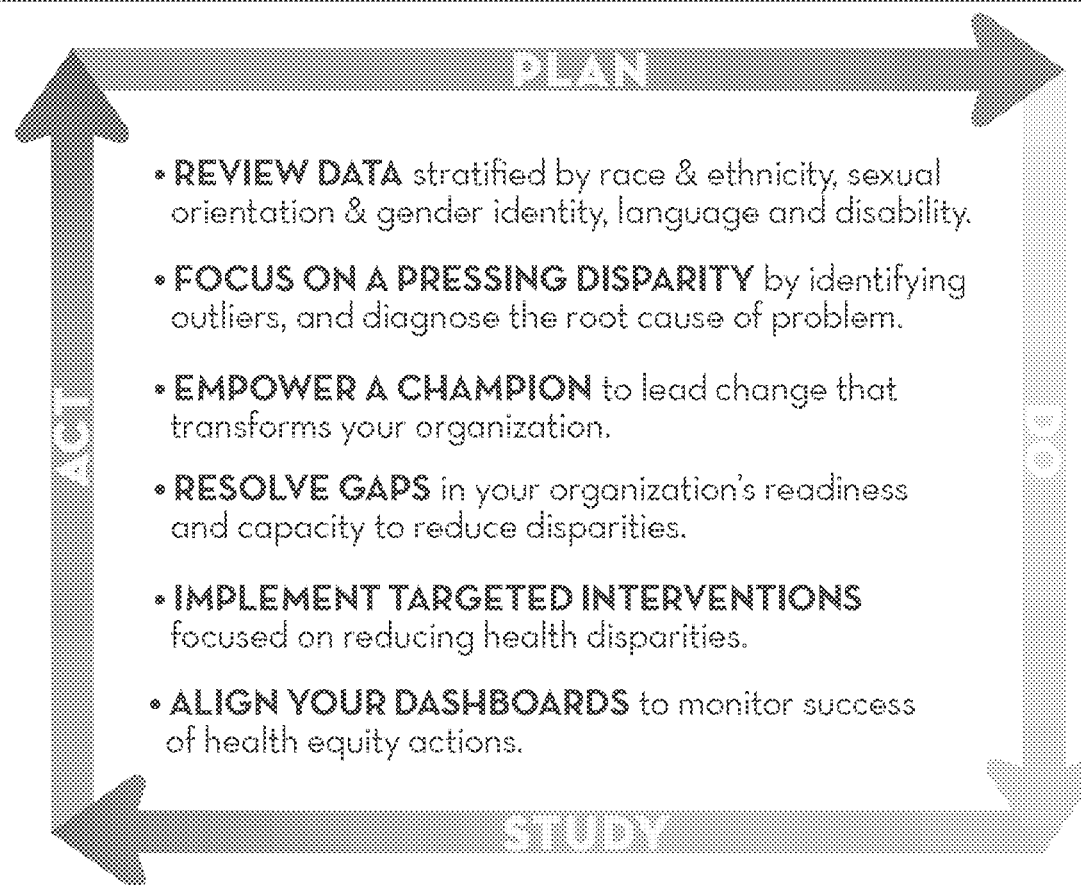
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BUILDING AN ORGANIZATIONAL RESPONSE TO HEALTH DISPARITIES



HEALTH EQUITY TECHNICAL ASSISTANCE

Learn how to **identify, prioritize, and take action** on health disparities in your organization. Participants receive personalized technical assistance focused on strengthening your quality improvement program through a series of consultations from subject matter experts. Contact us at HealthEquityTA@cms.hhs.gov to schedule a technical assistance consult and learn how to:



Health disparities are differences in health outcomes closely linked with social, economic, and environmental disadvantage – are often driven by the social conditions in which individuals live, learn, work, and play. Characteristics including race, ethnicity, disability, sexual orientation or gender identity, socio-economic status, geographic location, and other factors historically linked to exclusion or discrimination are associated with the health of individuals, families, and communities.

TECHNICAL ASSISTANCE: HOW WE HELP YOU IMPROVE

CONSULT 1



IDENTIFY
HEALTH
DISPARITIES

SET SMART
AIMS

CONSULT 2

IDENTIFY
GAPS

REVIEW
STRATIFIED
DASHBOARD

ADAPT
SOLUTIONS

CONSULT 3

EVALUATE
SUCCESS

SHARE
INSIGHTS

SUSTAIN
ACTION

PDSA

PDSA



“Working to Achieve Health Equity”

From: [Narayan, Anand K](#)
To: [CMS Health Equity TA](#)
Subject: Re: Disparities Impact Statement
Date: Tuesday, November 21, 2023 3:56:54 PM
Attachments: [image.png](#)

Wonderful - thank you so much! We look forward to highlighting this great tool in our publication

Best,

Anand

From: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>
Sent: Tuesday, November 21, 2023 2:48 PM
To: Narayan, Anand K <ANarayan@uwhealth.org>
Subject: Re: Disparities Impact Statement

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Dear Anand,

Thank you for reaching out to the CMS Health Equity Technical Assistance mailbox. Please feel free to use all or a portion of the Disparities Impact Statement Action Plan with the appropriate citation.

Thank you for your work advancing health equity,

Health Equity Technical Assistance Team

HealthEquityTA@cms.hhs.gov

CMS Office of Minority Health

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"Working to Achieve Health Equity"

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you are not the intended recipient, please be advised that any disclosure, copying, distribution, or use of the contents of this information is strictly prohibited. If you have received this communication in error, please notify the sender immediately and delete/destroy all copies of the original transmission.

From: Narayan, Anand K <ANarayan@uwhealth.org>
Sent: Monday, November 6, 2023 4:49 PM
To: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>
Subject: Disparities Impact Statement

Hello,

I'm writing an article for the Journal of the American College of Radiology. I was wondering if it might be possible to copy some version of the disparities impact statement action plan in one of our journal articles (with appropriate citation of course).

<https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Disparities-Impact-Statement-508-rev102018.pdf>

Thanks for your consideration,

Anand

Anand Narayan, MD, PhD (he/him)
Vice Chair of Equity
Associate Professor
Department of Radiology
University of Wisconsin-Madison
600 Highland Avenue, F6/178C
Madison, WI 53792-3252
Phone: 608-504-4689
Email: anand.narayan@wisc.edu

I am sending this message at a time that suits me. I don't expect you to read, reply, or take action on this outside of your regular working hours.



“Working to Achieve Health Equity”

From: [CMS Health Equity TA](#)
To: [Karla Cardoza](#)
Subject: Re: Do vendors qualify for the Health Equity Technical Assistance Program?
Date: Thursday, October 20, 2022 5:00:10 PM
Attachments: [image001.png](#)
[Technical Assistance.pdf](#)
[Outlook-x5qtxna.png](#)

Karla,

Yes, we provide TA to vendors. The TA we offer is flexible and tailored to whatever questions, ideas, or challenges you've got. Some examples of what we've done for other organizations (e.g.: hospitals, HIINs, health plans, QIN-QIOs, national and local provider associations and groups, and FQHCs and clinics) are:

- Help you draft or improve a strategic plan for your organization to address disparities over a few years with full support of your leadership, board, and staff (e.g.: a 5 year equity plan)
- Help you start thinking about your data and how to identify a particular disparity to focus on
- Help you find possible solutions to address a disparity you've identified – e.g.: an intervention for a particular population, training modules, and other strategies to improve the ability of your workforce to effectively treat the patients you serve
- Help you draft a CMS Disparities Impact Statement to structure your disparities work using a quality improvement approach and a PDSA cycle
- Help you draft a Language Access Plan to help your organization ensure you are addressing all of your patients' communication needs in a culturally appropriate and competent way
- Help you consider the physical accessibility, equipment, and training of staff in your clinical environment to ensure individuals with physical access challenges are able to get the care they need
- Help you find general or specific (depending on what you need) information, resources, and CMS data to help you address disparities in the population you serve

The first step is usually that we'd set up a time to talk with you for 30 minutes about what you're thinking of, so if you're interested in chatting please let us know and share a few dates/times that might work in your schedule.

I've also attached a two-pager that describes a bit more about our TA, how it works and what we offer. We also have a number of resources posted on our Health Equity TA website at go.cms.gov/healthequityTA, which we hope you will find helpful.

Thank you again for emailing – and for your work in helping to address health disparities.

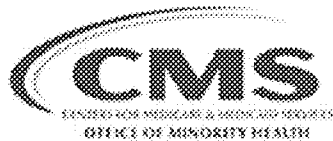
We look forward to working with you,

Health Equity Technical Assistance Team

HealthEquityTA@cms.hhs.gov

CMS Office of Minority Health

Visit us at [\[go.cms.gov/healthequityTA\]](https://go.cms.gov/healthequityTA)go.cms.gov/healthequityTA



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From: Karla Cardoza <kcardoza@prccustomresearch.com>

Sent: Wednesday, September 28, 2022 11:42 AM

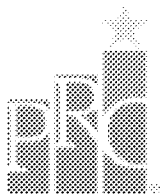
To: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>

Subject: Do vendors qualify for the Health Equity Technical Assistance Program?

Hello,

I attended last week's "Assessing Patient Experience for Insights into Enhancing Equity in Healthcare" virtual conference and was wondering if vendors can use the Health Equity Technical Assistance Program?

Thank you,



Karla Cardoza, MPH, CPXP

Consultant, Patient Experience

Direct: 402-933-9514

KCardoza@PRCCustomResearch.com

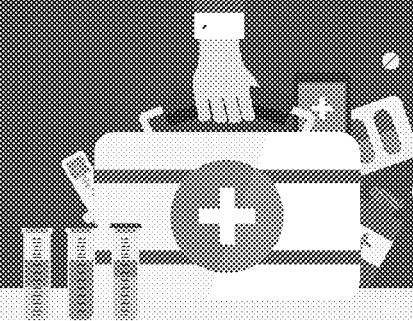
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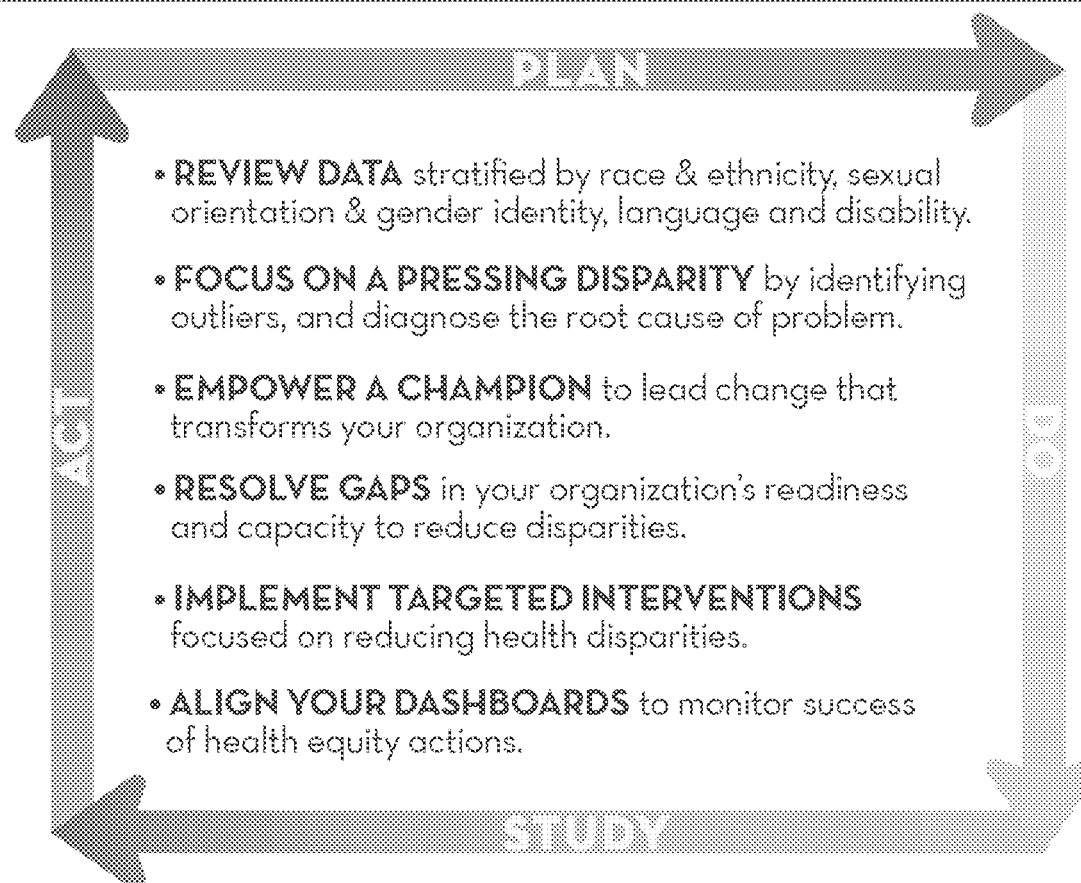


BUILDING AN ORGANIZATIONAL RESPONSE TO HEALTH DISPARITIES



HEALTH EQUITY TECHNICAL ASSISTANCE

Learn how to **identify, prioritize, and take action** on health disparities in your organization. Participants receive personalized technical assistance focused on strengthening your quality improvement program through a series of consultations from subject matter experts. Contact us at HealthEquityTA@cms.hhs.gov to schedule a technical assistance consult and learn how to:



Health disparities are differences in health outcomes closely linked with social, economic, and environmental disadvantage – are often driven by the social conditions in which individuals live, learn, work, and play. Characteristics including race, ethnicity, disability, sexual orientation or gender identity, socio-economic status, geographic location, and other factors historically linked to exclusion or discrimination are associated with the health of individuals, families, and communities.

TECHNICAL ASSISTANCE: HOW WE HELP YOU IMPROVE

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ADAPT
SOLUTIONS

CONSULT 3

EVALUATE
SUCCESS

SHARE
INSIGHTS

SUSTAIN
ACTION

PDSA

PDSA



“Working to Achieve Health Equity”

From: [CMS Health Equity TA](#)
To: [Andy J. Wessel \(DCHD\)](#)
Subject: Re: Edit to Action Plan of Disparities Impact Statement
Date: Thursday, August 4, 2022 5:42:03 PM
Attachments: [OMH Disparities Impact Statement April2021_508.pdf](#)
[Outlook-agpgeafw.png](#)

Dear Andy,

Thank you for reaching out to the Health Equity Team Technical Assistance team. Attached please find the Disparities Impact Statement, the Long-term goal field should allow the text to wrap.

Thank you for your work advancing health equity,

Health Equity Technical Assistance Team

HealthEquityTA@cms.hhs.gov

CMS Office of Minority Health

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From: Andy J. Wessel (DCHD) <andy.wessel@douglascounty-ne.gov>

Sent: Tuesday, July 5, 2022 5:25 PM

To: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>

Subject: Edit to Action Plan of Disparities Impact Statement

We are trying to use the Disparities Impact Statement document -- particularly the Action Plan on page 7 which is an editable PDF. The only issue is that the field for Long-Term goal doesn't wrap text like all the other fields. Do you have a version where that has been corrected?

Andy

<https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Disparities-Impact-Statement-508-rev102018.pdf>

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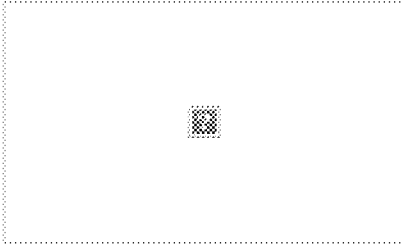
Andy Wessel
Community Health Planner
Douglas County Health Department

1111 S. 41st Street

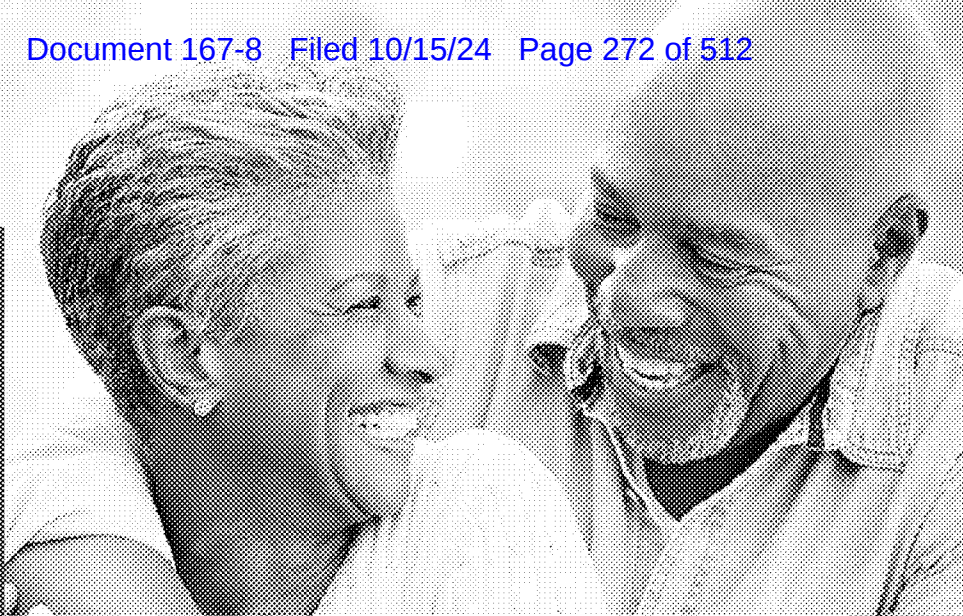
Omaha, NE 68105

Phone 402-444-7225

andy.wessel@douglascounty-ne.gov



Disparities Impact Statement



This tool can be used by all health care stakeholders to achieve health equity for racial and ethnic minorities, people with disabilities, sexual and gender minorities, individuals with limited English proficiency, and rural populations.

This worksheet has 5 steps:

- 1** Identify health disparities and priority populations
- 2** Define your goals
- 3** Establish your organization's health equity strategy
- 4** Determine what your organization needs to implement its strategy
- 5** Monitor and evaluate your progress

Health disparities—differences in health outcomes closely linked with social, economic, and environmental disadvantage—are often driven by the social conditions in which individuals live, learn, work, and play.

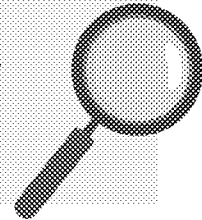


STEP 1:

Identify health disparities and priority populations

Use available data sources to help you identify and prioritize which population(s) and health disparities you want to address.

Stratifying measures and health outcomes by race and ethnicity can help you get started.



What data can you use to identify health disparities and/or your priority population(s)?

What population(s) will you prioritize?

What health disparities do you want to address?

STEP 2:

Define your goals

Using the information from **STEP 1**, set out what you aim to do, by when, and with whom.

For example:

Implement a **Language Access Plan** for patients with limited English proficiency.

- Develop a high quality language access plan in Year 1 (short-term goal).
- Train 90% of staff on the language access plan in Year 2 (long-term goal).

What do you want to improve or accomplish?

Short-term goal:

Long-term goal:

STEP 3:

Establish your organization's health equity strategy

List out the actions needed to achieve your **STEP 2** improvement goals.

What specific actions are needed to achieve your organization's goals?

Actions to reach the short-term goal:

Actions to reach the long-term goal:

STEP 4:

Determine what your organization needs to implement its health equity strategy

Identify the policy changes and resources needed to achieve your strategy from **STEP 3**. For example, more staff, leadership support, changes to policies, or investment in technology.

Stakeholder Engagement Plan

Important: Develop a roadmap for how your team will engage and collaborate with internal and external partners.



What policy changes and resources are needed to achieve your organization's goals?

Resources you already have (assets):

Resources and/or policy changes you still need (deficits):

STEP 5:

Monitor and evaluate your progress

Establish what you will measure and agree on a plan to track progress.

Set your baseline: measure before you take action.



What measures can you use to track progress?

Visit the CMS Measures Inventory for ideas.

Who is responsible for the evaluation and how frequently will they provide updates?

Next: Complete the Action Plan to develop and implement a Disparities Action Statement.

Contact HealthEquityTA@cms.hhs.gov for assistance completing the Disparities Impact Statement.

ACTION PLAN

Fill out one for each improvement goal. Health Equity Technical Assistance is available for stakeholders completing the Disparities Impact Statement. Contact HealthEquityTA@cms.hhs.gov.

Health Equity Champion:

Executive Sponsor:

Date:

Improvement Goal

What health disparity are you addressing and who is (are) your priority population(s)?

Health Disparity:

Priority Populations(s):

Goals	Action Steps	Resources & Key Stakeholders	Metrics	Measurable Outcomes/Impact
List out your short-term and long-term goals from Step 2. Add rows as needed.	List the action steps needed to achieve your goals.	List the resources needed to accomplish action steps, including key staff or stakeholders from the Stakeholder Engagement Plan.	What will you monitor? What data will you use to track progress and how often?	Consider the longer term outcomes: how will you evaluate the impact and sustainability of your actions?
Short-Term Goal				
Long-Term Goal				



“Working to Achieve Health Equity”

From: Abigail Berube
To: CMS Health Equity TA
Subject: RE: example action plans
Date: Monday, October 23, 2023 2:17:24 PM
Attachments: image002.png
 image003.png

Thank you for your replay and for sharing the additional tools, this is helpful!

Abby

From: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>
Sent: Monday, October 23, 2023 10:19 AM
To: Abigail Berube <AbigailB@wsha.org>
Subject: Re: example action plans

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DO NOT click links or open attachments if the sender is unknown or the email was unsolicited and **never** provide your User ID or Password.

Dear Abby,

Thank you for reaching out to the CMS Health Equity Technical Assistance mailbox. Unfortunately, we are unable to share examples of completed disparities impact statements. There are many organizations that post information online and we encourage you to explore examples that may be relevant to you in your context.

If you're looking for additional information and guidance please see the following resources:

- [HHS OMH Disparity Impact Strategy](#): provides an overview of HHS OMH's strategy and guidance for grantees to complete a DIS.
- [ASPE In-depth equity assessment guide](#): This tool describes how to conduct intensive equity assessments of existing programs, policies, and processes. It is not identical to the DIS but follows a similar process and may be another useful way to think about your health disparities statement.
 - <https://aspe.hhs.gov/reports/equity-assessment-tip-sheet>: This provides tips on completing each of the 6 steps of the equity assessment.

Thank you for your work advancing health equity,

Health Equity Technical Assistance Team

HealthEquityTA@cms.hhs.gov

CMS Office of Minority Health

Visit us at go.cms.gov/healthequityTA



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From: Abigail Berube <AbigailB@wsha.org>
Sent: Monday, October 16, 2023 3:07 PM
To: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>
Subject: example action plans

Good afternoon,

Thank you for creating and making available the Disparities Impact Statement tool. Do you also have available **example completed plans**? I

would like to share examples with hospitals who are working to complete health disparities action plans. Thank you in advance for your assistance!

Sincerely,
Abby

Abigail Berube, MPH, CPHQ
Director, Safety and Quality
Health Equity, Patient and Family Engagement
Washington State Hospital Association
999 Third Avenue, Suite 1400
Seattle, WA 98104
(206) 216-2544
Pronouns: She/Her



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“Working to Achieve Health Equity”

FOSTER
SCHOOL OF BUSINESS

**Diversity, Equity
and Inclusion**



CERTIFICATE

W

From: [CMS Health Equity TA](#)
To: [Amy Murawski](#)
Subject: Re: examples
Date: Wednesday, May 3, 2023 5:56:25 PM
Attachments: [image001.png](#)
[image.png](#)

Dear Amy,

Thank you for reaching out to the Health Equity TA Mailbox. CMS developed a [Disparities Impact Statement \(DIS\) resource](#). You may find it helpful to walk through this brief worksheet to create a DIS. If you're looking for additional information and guidance please see the following resources:

- [HHS OMH Disparity Impact Strategy](#): provides an overview of HHS OMH's strategy and guidance for grantees to complete a DIS.
- [ASPE In-depth equity assessment guide](#): This tool describes how to conduct intensive equity assessments of existing programs, policies, and processes. It is not identical to the DIS but follows a similar process and may be another useful way to think about your health disparities statement.
 - <https://aspe.hhs.gov/reports/equity-assessment-tip-sheet>: This provides tips on completing each of the 6 steps of the equity assessment.

Thank you for your work advancing health equity,

Health Equity Technical Assistance Team

HealthEquityTA@cms.hhs.gov

CMS Office of Minority Health

Visit us at [\[go.cms.gov/healthequityTA\]](https://go.cms.gov/healthequityTA)go.cms.gov/healthequityTA



"Working to Achieve Health Equity"

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From: Amy Murawski <Amy.Murawski@tn.gov>

Sent: Friday, April 28, 2023 8:48 AM

To: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>

Subject: examples

Can you provide some examples of a health disparities statement process



Amy Murawski | Director
Overdose Response Coordination
2nd Floor, Andrew Johnson Tower
710 James Robertson Parkway
Nashville, Tennessee 37243
c. 615-922-0317 f. 615-253-1689
Amy.Murawski@tn.gov

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TN

Department of

Health



“Working to Achieve Health Equity”

From: CMS Health Equity TA
To: Ronald Williams
Subject: Re: Grants To An Non-Profit Organizations
Date: Wednesday, August 17, 2022 10:07:16 AM
Attachments: Outlook-5ppa1tlh.png

Dear Ron,

Thank you for contacting the CMS Health Equity Technical Assistance Program. The TA we offer is flexible and tailored to whatever questions, ideas, or challenges you've got. Some examples of what we've done for other organizations (e.g.: hospitals, HIINs, health plans, QIN-QIOs, national and local provider associations and groups, and FQHCs and clinics) are:

- Help you find general or specific (depending on what you need) information, resources, and CMS data to help you address disparities in the population you serve
- Help you draft a Language Access Plan to help your organization ensure you are addressing all of your patients' communication needs in a culturally appropriate and competent way
- Help you find possible solutions to address a disparity you've identified – e.g.: an intervention for a particular population, training modules, and other strategies to improve the ability of your workforce to effectively treat the patients you serve
- Help you draft or improve a strategic plan for your organization to address disparities over a few years with full support of your leadership, board, and staff (e.g.: a 5 year equity plan)
- Help you start thinking about your data and how to identify a particular disparity to focus on
- Help you draft a CMS Disparities Impact Statement to structure your disparities work using a quality improvement approach and a PDSA cycle
- Help you consider the physical accessibility, equipment, and training of staff in your clinical environment to ensure individuals with physical access challenges are able to get the care they need

We also have a number of resources posted on our [Health Equity TA website](#), which we hope you will find helpful.

Is this the kind of support you are interested in? There are also local CMS points of contact that work more locally to provide education and answer question. You can look for your local contact here:

<https://www.cms.gov/Medicare/Coding/ICD10/CMS-Regional-Offices>

Please let us know if you have additional questions.

Thank you,

Health Equity Technical Assistance Team

HealthEquityTA@cms.hhs.gov

CMS Office of Minority Health

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From: CMS OMH <OMH@cms.hhs.gov>
Sent: Tuesday, July 19, 2022 10:46 AM
To: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>
Subject: FW: Grants To An Non-Profit Organizations

Hello CMS Health Equity TA Team,

Please see the email below that was sent to the OMH mailbox regarding a potential technical assistance request.

Regards,
CMS/OMH

-----Original Message-----

From: Ronald Willams <rwgoldbank@icloud.com>
Sent: Tuesday, July 19, 2022 7:45 AM
To: CMS OMH <OMH@cms.hhs.gov>
Subject: Grants To An Non-Profit Organizations

Re: Information Requested

Please email reply, with contact information on who to speak with regarding teaching, counseling, and helping the underserve and un educated in the Fort Bend County area.

Ron Williams
832-483-2345

Thanks

Sent from my iPhone



“Working to Achieve Health Equity”

From: CMS Health Equity TA
To: Alissa Wood
Subject: Re: Health Disparities Guide
Date: Thursday, October 27, 2022 11:00:50 AM
Attachments: [image001.png](#)
[image002.png](#)
[image003.png](#)
[image004.png](#)
[image005.png](#)
[Outlook-j2dvxyih.png](#)

Dear Alissa,

Thank you for contacting the CMS Health Equity Technical Assistance Program. The resource you attached is not current. You may find the CMS [Disparities Impact Statement](#) a useful tool for structuring your disparities work using a quality improvement approach and a PDSA cycle. To see other tools and resources available from the CMS Office of Minority Health, we encourage you to visit our [Resource Center](#), where you can find resources on our [Health Equity Technical Assistance page](#), [Quality Improvement & Interventions page](#), and more.

Thank you for your work to advance health equity.

Sincerely,

Health Equity Technical Assistance Team

HealthEquityTA@cms.hhs.gov

CMS Office of Minority Health

Visit us at [\[go.cms.gov/healthequityTA\]](https://go.cms.gov/healthequityTA)go.cms.gov/healthequityTA



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From: Alissa Wood <alissa.wood@greatplainsqn.org>
Sent: Tuesday, October 11, 2022 9:33 AM
To: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>
Subject: Health Disparities Guide

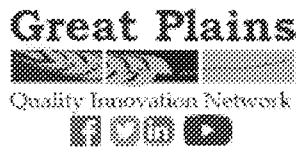
Hello,

I found this CMS resource and was wondering if this is the most up to date version of this document. Is this something you could help me with?

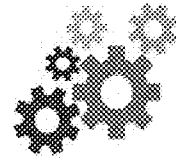
Thank you,
Alissa Wood

[Visit our Web site for COVID-19 resources and updates](#)

Alissa Wood, RN, BSN

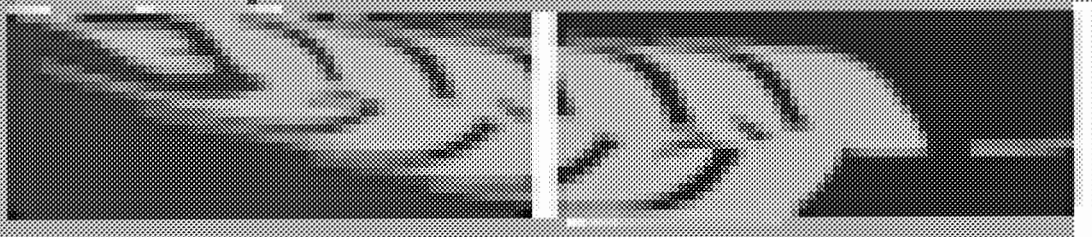


Quality Improvement Advisor
Great Plains Quality Innovation
Network
402-972-8602 (Office)
alissa.wood@greatplainsqin.org



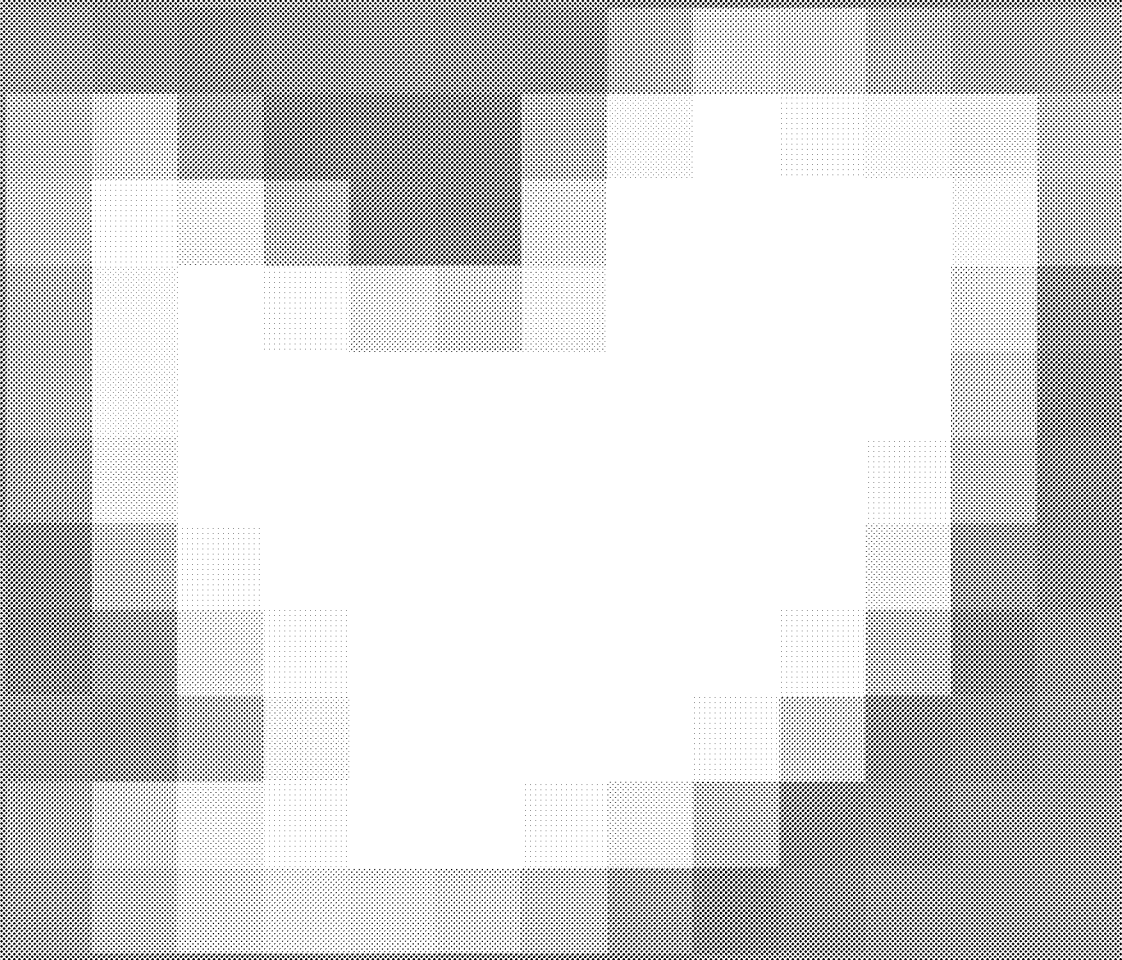
Great Plains Quality Care Coalition. Better together.

Great Plains



Quality Innovation Network











“Working to Achieve Health Equity”

From: [CMS Health Equity TA](#)
To: [Monica Stanton \(DHHS\)](#)
Subject: Re: Health Equity
Date: Thursday, August 11, 2022 1:16:51 PM
Attachments: [Outlook-puskuvs.png](#)

Dear Monica,

Thank you for contacting the CMS Health Equity Technical Assistance Program. The TA we offer (at no cost) is flexible and tailored to whatever questions, ideas, or challenges you've got. Some examples of what we've done for other organizations (e.g.: hospitals, HIINs, health plans, QIN-QIOs, national and local provider associations and groups, and FQHCs and clinics) are:

- Help you draft or improve a strategic plan for your organization to address disparities over a few years with full support of your leadership, board, and staff (e.g.: a 5 year equity plan)
- Help you start thinking about your data and how to identify a particular disparity to focus on
- Help you find possible solutions to address a disparity you've identified – e.g.: an intervention for a particular population, training modules, and other strategies to improve the ability of your workforce to effectively treat the patients you serve
- Help you draft a CMS Disparities Impact Statement to structure your disparities work using a quality improvement approach and a PDSA cycle
- Help you draft a Language Access Plan to help your organization ensure you are addressing all of your patients' communication needs in a culturally appropriate and competent way
- Help you consider the physical accessibility, equipment, and training of staff in your clinical environment to ensure individuals with physical access challenges are able to get the care they need
- Help you find general or specific (depending on what you need) information, resources, and CMS data to help you address disparities in the population you serve

The first step is usually that we'd set up a time to talk with you for 30 minutes about what you're thinking of, so if you're interested in chatting please let us know and share a few dates/times that might work in your schedule. We are happy to chat!

We also have a number of resources posted on our [Health Equity TA website](#), which we hope you will find helpful.

We look forward to working with you!

Health Equity Technical Assistance Team

HealthEquityTA@cms.hhs.gov

CMS Office of Minority Health

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From: Monica Stanton (DHHS) <mstanton@utah.gov>
Sent: Wednesday, July 27, 2022 7:17 PM
To: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>
Subject: Health Equity

Hello

My name is Monica Stanton. I am the health equity coordinator for the Central Utah Public Health Department. Health equity is a new program for our health department. We serve six counties in rural central Utah. I would love any suggestions or help on promoting health equity within our programs and counties.

Thank you

Monica Stanton (she/her)
Health Equity Coordinator
Central Utah Public Health Dept.
(435) 896-5451 x330
mstanton@utah.gov

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“Working to Achieve Health Equity”

From: [CMS Health Equity TA](#)
To: [Cornejo, Rosita \[DOH\]](#)
Cc: [Torres, Glenda \[DOH\]](#); [Morrison, Chris \[DOH\]](#); [Conover, Diane \[DOH\]](#)
Subject: Re: Healthcare Equity
Date: Thursday, November 17, 2022 5:52:51 PM
Attachments: [Technical Assistance.pdf](#)
[image.png](#)

Hello,

Thank you for contacting the CMS Health Equity Technical Assistance Program. The TA we offer is flexible and tailored to whatever questions, ideas, or challenges you've got. Some examples of what we've done for other organizations (e.g.: hospitals, HIINs, health plans, QIN-QIOs, national and local provider associations and groups, and FQHCs and clinics) are:

- Help you draft or improve a strategic plan for your organization to address disparities over a few years with full support of your leadership, board, and staff (e.g.: a 5 year equity plan)
- Help you start thinking about your data and how to identify a particular disparity to focus on
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- Help you draft a CMS Disparities Impact Statement to structure your disparities work using a quality improvement approach and a PDSA cycle
- Help you draft a Language Access Plan to help your organization ensure you are addressing all of your patients' communication needs in a culturally appropriate and competent way
- Help you consider the physical accessibility, equipment, and training of staff in your clinical environment to ensure individuals with physical access challenges are able to get the care they need
- Help you find general or specific (depending on what you need) information, resources, and CMS data to help you address disparities in the population you serve

The first step is usually that we'd set up a time to talk with you for 30 minutes about what you're thinking of, so if you're interested in chatting please let us know and share a few dates/times that might work in your schedule. We are happy to chat!

I've also attached a two-pager that describes a bit more about our TA, how it works and what we offer. We also have a number of resources posted on our Health Equity TA website at go.cms.gov/healthequityTA, which we hope you will find helpful.

Thank you again for emailing – and for your work in helping to address health disparities!
 We look forward to working with you!

Health Equity Technical Assistance Team

HealthEquityTA@cms.hhs.gov

CMS Office of Minority Health

Visit us at [go.cms.gov/healthequityTA]go.cms.gov/healthequityTA



"Working to Achieve Health Equity"

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From: Cornejo, Rosita [DOH] <Rosita.Cornejo2@doh.nj.gov>

Sent: Thursday, November 10, 2022 12:10 PM

To: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>

Cc: Torres, Glenda [DOH] <Glenda.Torres@doh.nj.gov>; Morrison, Chris [DOH] <Chris.Morrison@doh.nj.gov>; Conover, Diane [DOH] <Diane.Conover@doh.nj.gov>

Subject: Healthcare Equity

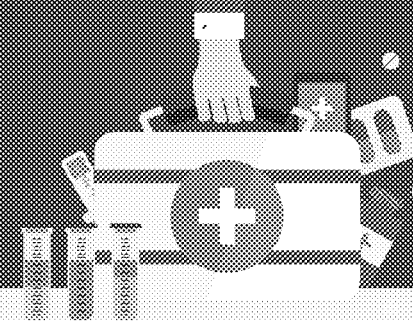
Good Afternoon, we are work at 4 large state psychiatrics in New Jersey and are looking for technical assistance for a way to promote health equity in our hospitals but aren't sure where to start. I saw that CMS OMH offers health equity technical assistance resources aimed to help health care organizations take action against health disparities. We would appreciate any assistance you can offer.

Thank you in advance.

Rosita Cornejo

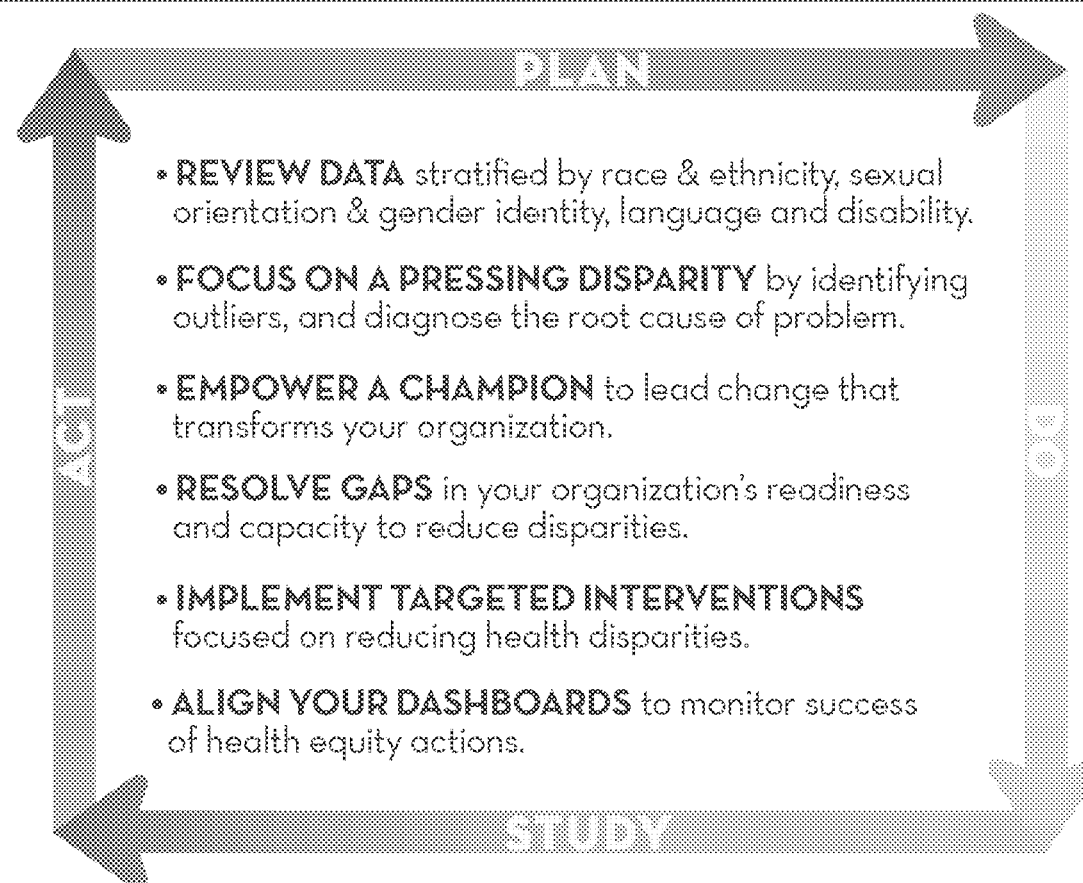
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BUILDING AN ORGANIZATIONAL RESPONSE TO HEALTH DISPARITIES



HEALTH EQUITY TECHNICAL ASSISTANCE

Learn how to **identify, prioritize, and take action** on health disparities in your organization. Participants receive personalized technical assistance focused on strengthening your quality improvement program through a series of consultations from subject matter experts. Contact us at HealthEquityTA@cms.hhs.gov to schedule a technical assistance consult and learn how to:



Health disparities are differences in health outcomes closely linked with social, economic, and environmental disadvantage – are often driven by the social conditions in which individuals live, learn, work, and play. Characteristics including race, ethnicity, disability, sexual orientation or gender identity, socio-economic status, geographic location, and other factors historically linked to exclusion or discrimination are associated with the health of individuals, families, and communities.

TECHNICAL ASSISTANCE: HOW WE HELP YOU IMPROVE

CONSULT 1



IDENTIFY
HEALTH
DISPARITIES

SET SMART
AIMS

CONSULT 2

IDENTIFY
GAPS

REVIEW
STRATIFIED
DASHBOARD

ADAPT
SOLUTIONS

CONSULT 3

EVALUATE
SUCCESS

SHARE
INSIGHTS

SUSTAIN
ACTION

PDSA

PDSA



“Working to Achieve Health Equity”

From: CMS Health Equity TA
To: Bryden, Alexandra (CMS/OMH); Graves, Darci (CMS/OMH); Saumya Khanna (she/her); Phoebe Lamuda; Mollie Hertel (Hertel-Mollie@norc.org); Cornejo, Rosita [DOH]
Subject: CMS OMH/NJ DOH Health Equity TA - Ancora Psychiatric Hospital
Start: Thursday, February 2, 2023 10:00:00 AM
End: Thursday, February 2, 2023 10:30:00 AM

Request:

Our steering group met a couple of weeks ago to brainstorm what some areas may be that maybe be impacted by healthcare disparities. Our brainstorming led to good discussion and we want to focus only on those areas that are within the hospital's control. Some areas that might be beneficial to investigate further: provision of treatment in language of choice (the group felt Ancora does well with this); use of restraint; Length of Stay; medication management (are patients medicated differently by race or ethnic background); pain management (how quickly is a patient's pain being treated, what medications are given, is the management of chronic pain in the patient's treatment plan).

We know we need data exploration with any of the topics chosen but there may be a barrier in that we may not have data to make informed decisions or if there is data available it is not captured in a way that it can be aggregated in order to have it be useful to make informed decisions or to even have a baseline.

Join Zoom Meeting

<https://norc.zoom.us/j/83555495238?pwd=YnFkZEtSV05vdmF0aDIrWFVXa1dYQT09>

Meeting ID: 835 5549 5238

Password: 330809

One tap mobile

+13092053325,,83555495238# US

+13126266799,,83555495238# US (Chicago)

Dial by your location

+1 309 205 3325 US

+1 312 626 6799 US (Chicago)

+1 646 558 8656 US (New York)

+1 646 931 3860 US

+1 301 715 8592 US (Washington DC)

+1 305 224 1968 US

+1 507 473 4847 US

+1 564 217 2000 US

+1 669 444 9171 US

+1 669 900 6833 US (San Jose)

+1 689 278 1000 US

+1 719 359 4580 US

+1 253 205 0468 US

+1 253 215 8782 US (Tacoma)

+1 346 248 7799 US (Houston)

+1 360 209 5623 US

+1 386 347 5053 US

877 853 5247 US Toll-free

888 788 0099 US Toll-free

833 548 0276 US Toll-free

833 548 0282 US Toll-free

Meeting ID: 835 5549 5238

Find your local number: <https://norc.zoom.us/j/keHjRfqty9>

Join by SIP

83555495238@zoomerc.com

From: CMS Health Equity TA
To: Cornejo, Rosita [DOH]
Cc: Torres, Glenda [DOH]; Cooper, Kandice [DOH]; Moore, Natasha [DOH]; Conover, Diane [DOH]; Morrison, Chris [DOH]; Kuper, Colleen [DOH]; Tornatore, James [DOH]
Subject: Re: Scheduling a health equity TA call between CMS OMH and NJ Dept. of Health
Date: Wednesday, January 25, 2023 4:46:19 PM
Attachments: Outlook-f41scp3d.png

Hello Rosita,

I will send an invite out shortly. Please forward to any colleagues you'd like to include.

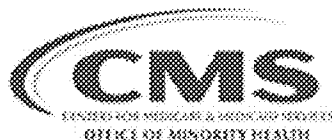
Thank you for your patience,

Health Equity Technical Assistance Team

HealthEquityTA@cms.hhs.gov

CMS Office of Minority Health

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From: Cornejo, Rosita [DOH] <Rosita.Cornejo2@doh.nj.gov>

Sent: Wednesday, January 25, 2023 2:36 PM

To: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>

Cc: Torres, Glenda [DOH] <Glenda.Torres@doh.nj.gov>; Cooper, Kandice [DOH] <Kandice.Cooper@doh.nj.gov>; Moore, Natasha [DOH] <Natasha.Moore@doh.nj.gov>; Conover, Diane [DOH] <Diane.Conover@doh.nj.gov>; Morrison, Chris [DOH] <Chris.Morrison@doh.nj.gov>; Kuper, Colleen [DOH] <Colleen.Kuper@doh.nj.gov>; Tornatore, James [DOH] <James.Tornatore@doh.nj.gov>; Cornejo, Rosita [DOH] <Rosita.Cornejo2@doh.nj.gov>

Subject: Re: Scheduling a health equity TA call between CMS OMH and NJ Dept. of Health

We can do Thursday morning, February 2nd at 10, 10:30, or 11. Rosita Cornejo, Ancora Psychiatric Hospital

From: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>

Sent: Tuesday, January 24, 2023 4:40 PM

To: Cornejo, Rosita [DOH] <Rosita.Cornejo2@doh.nj.gov>

Cc: Torres, Glenda [DOH] <Glenda.Torres@doh.nj.gov>; Cooper, Kandice [DOH] <Kandice.Cooper@doh.nj.gov>; Moore, Natasha [DOH] <Natasha.Moore@doh.nj.gov>; Conover, Diane [DOH] <Diane.Conover@doh.nj.gov>; Morrison, Chris [DOH] <Chris.Morrison@doh.nj.gov>; Kuper, Colleen [DOH] <Colleen.Kuper@doh.nj.gov>

Subject: [EXTERNAL] Re: Scheduling a health equity TA call between CMS OMH and NJ Dept. of Health

Good afternoon,

I apologize for the delay. Our team is no longer available for a call on Thursday, January 26. Can you please provide additional days and times late next week (Wednesday or Thursday) when your team might be available?

Thank you for your understanding,

CMS Health Equity TA team

From: Cornejo, Rosita [DOH] <Rosita.Cornejo2@doh.nj.gov>

Sent: Tuesday, January 24, 2023 1:52 PM

To: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>

Cc: Torres, Glenda [DOH] <Glenda.Torres@doh.nj.gov>; Cooper, Kandice [DOH] <Kandice.Cooper@doh.nj.gov>; Moore, Natasha [DOH] <Natasha.Moore@doh.nj.gov>; Conover, Diane [DOH] <Diane.Conover@doh.nj.gov>; Morrison, Chris [DOH] <Chris.Morrison@doh.nj.gov>; Kuper, Colleen [DOH] <Colleen.Kuper@doh.nj.gov>

Subject: RE: Scheduling a health equity TA call between CMS OMH and NJ Dept. of Health

Good afternoon. What number should we call on the 26th at 12:30 or are you going to call us? We also have Teams capability to have a meeting. Thank you in advance. Rosita Cornejo

From: Cornejo, Rosita [DOH]

Sent: Tuesday, January 17, 2023 2:36 PM

To: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>; Josephs-Spaulding, Dorothea [DOH] <Dorothea.Josephs-Spaulding@doh.nj.gov>

Cc: Torres, Glenda [DOH] <Glenda.Torres@doh.nj.gov>; Cooper, Kandice [DOH] <Kandice.Cooper@doh.nj.gov>; Moore, Natasha [DOH] <Natasha.Moore@doh.nj.gov>; Conover, Diane [DOH] <Diane.Conover@doh.nj.gov>; Morrison, Chris [DOH] <Chris.Morrison@doh.nj.gov>; Kuper, Colleen [DOH] <Colleen.Kuper@doh.nj.gov>; Cornejo, Rosita [DOH] <Rosita.Cornejo2@doh.nj.gov>

Subject: RE: Scheduling a health equity TA call between CMS OMH and NJ Dept. of Health

Good Afternoon. January 26 from 12:30 to 1 works for Ancora Psychiatric Hospital. I have copied those individuals involved with this. Looking forward to the call. I'll send the contact phone number in a different message. Rosita Cornejo

From: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>

Sent: Tuesday, January 17, 2023 1:27 PM

To: Cornejo, Rosita [DOH] <Rosita.Cornejo2@doh.nj.gov>; Josephs-Spaulding, Dorothea [DOH] <Dorothea.Josephs-Spaulding@doh.nj.gov>

Subject: [EXTERNAL] Scheduling a health equity TA call between CMS OMH and NJ Dept. of Health

Dear Dorothea and Rosita,

Thank you both for contacting the CMS Health Equity Technical Assistance Team. You each expressed interest in speaking with our team to support your efforts to reduce health disparities; Rosita, you identified specific topic areas for the psychiatric hospital you work with to focus on.

Below are some times that work for the CMS Office of Minority Health (OMH) Health Equity TA Team to participate in a TA call with staff from the New Jersey Department of Health. Can you each respond and share your availability so we can identify the best time for a call?

1/26: 12:30-1 pm ET

1/30: 3:30-4 pm ET

2/1: 3:30-4 pm ET

Sincerely,

Health Equity Technical Assistance Team

HealthEquityTA@cms.hhs.gov

CMS Office of Minority Health

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“Working to Achieve Health Equity”

From: CMS Health Equity TA
To: cnahabedian@vkdigitalhealth.com
Subject: Re: Healthcare for the minority communities
Date: Thursday, September 15, 2022 2:11:58 PM
Attachments: image002.png
 Outlook-Itkqx1b4.png

Dear Charles,

Thank you for your response. We are not able to assist in filling out materials, however we are happy to review any materials or strategy documents you have created related to health equity in your organization. Please let us know if you're interested in sharing materials or scheduling a 30-minute meeting.

Sincerely,

Health Equity Technical Assistance Team

HealthEquityTA@cms.hhs.gov

CMS Office of Minority Health

Visit us at [\[go.cms.gov/healthequityTA\]](https://go.cms.gov/healthequityTA)go.cms.gov/healthequityTA



"Working to Achieve Health Equity"

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From: cnahabedian@vkdigitalhealth.com <cnahabedian@vkdigitalhealth.com>
Sent: Sunday, August 28, 2022 3:38 PM
To: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>
Subject: RE: Healthcare for the minority communities

Folks,

This is super. How do I get started?

Charlie Nahabedian
 CEO, VK Digital Health
 Bethesda, MD 20817
<https://www.linkedin.com/in/cnahabedian/>
 C: 201-704-0730
www.vkdigitalhealth.com
<https://calendly.com/cnahabedian>

From: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>
Sent: Wednesday, August 17, 2022 9:57 AM
To: Charles Nahabedian <cnahabedian@vkdigitalhealth.com>
Subject: Re: Healthcare for the minority communities

Dear Charlie,

The TA we offer (at no cost) is flexible and tailored to whatever questions, ideas, or challenges you've got. Some examples of what we've done for other organizations (e.g.: hospitals, HIINs, health plans, QIN-QIOs, national and local provider associations and groups, and FQHCs and clinics) are:

- Help you draft or improve a strategic plan for your organization to address disparities over a few years with full support of your

- leadership, board, and staff (e.g.: a 5 year equity plan)
- Help you start thinking about your data and how to identify a particular disparity to focus on
 - Help you find possible solutions to address a disparity you've identified – e.g.: an intervention for a particular population, training modules, and other strategies to improve the ability of your workforce to effectively treat the patients you serve
 - Help you draft a CMS Disparities Impact Statement to structure your disparities work using a quality improvement approach and a PDSA cycle
 - Help you draft a Language Access Plan to help your organization ensure you are addressing all of your patients' communication needs in a culturally appropriate and competent way
 - Help you consider the physical accessibility, equipment, and training of staff in your clinical environment to ensure individuals with physical access challenges are able to get the care they need
 - Help you find general or specific (depending on what you need) information, resources, and CMS data to help you address disparities in the population you serve

We also have a number of resources posted on our [Health Equity TA website](#), which we hope you will find helpful.

We hope this is helpful information to you, do let us know if there is something more specific along these lines we could assist with.

Continued best of luck in your work,

Health Equity Technical Assistance Team

HealthEquityTA@cms.hhs.gov

CMS Office of Minority Health

Visit us at [\[go.cms.gov/healthequityTA\]](https://go.cms.gov/healthequityTA)go.cms.gov/healthequityTA



"Working to Achieve Health Equity"

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From: Charles Nahabedian <cnahabedian@vkdigitalhealth.com>

Sent: Thursday, August 11, 2022 1:26 PM

To: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>

Subject: Re: Healthcare for the minority communities

Thanks for the good wishes. Where/how do I apply for the program?

Sent from my iPhone

On Aug 11, 2022, at 1:18 PM, CMS Health Equity TA <HealthEquityTA@cms.hhs.gov> wrote:

Dear Charlie,

Thank you for reaching out to the CMS Health Equity Technical Assistance Program and for sharing the capabilities of your platform.

Best of luck,

Health Equity Technical Assistance Team

HealthEquityTA@cms.hhs.gov

CMS Office of Minority Health

Visit us at [\[go.cms.gov/healthequityTA\]](https://go.cms.gov/healthequityTA)go.cms.gov/healthequityTA



“Working to Achieve Health Equity”

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From: cnahabedian@vkdigitalhealth.com <cnahabedian@vkdigitalhealth.com>

Sent: Thursday, July 14, 2022 3:27 PM

To: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>

Subject: Healthcare for the minority communities

I read with great interest regarding your focus on minority communities, including rural where healthcare equity is needed. I will add that there is a similar need in urban enclaves where there are few if any doctors, walk-in clinics, and the like.

Our platform was designed to accomplish three main objectives to solve this challenge:

- Improve access to healthcare, and the quality of that access
- Be able to place clinics (unattended by the patient) in any location on this earth, whether there is broadband fiber/cable or not.
- That the cost of service be less than a trip to the doctors, walk-in clinic or ER

I would be pleased to meet with you to discuss this and the many other positive implications of this application.

Charlie Nahabedian

CEO, VK Digital Health

Bethesda, MD 20817

<https://www.linkedin.com/in/cnahabedian/>

C: 201-704-0730

www.vkdigitalhealth.com

<https://calendly.com/cnahabedian>



“Working to Achieve Health Equity”



“Working to Achieve Health Equity”

From: [CMS Health Equity TA](#)
To: [Thomas, Andrew](#)
Subject: Re: Help Needed
Date: Thursday, November 10, 2022 9:50:34 AM
Attachments: [Technical Assistance.pdf](#)
[Outlook-nzial1gw.png](#)

Dear Andrew,

Thank you for contacting the CMS Health Equity Technical Assistance Program and for your interest in advancing health equity. To help us better assist you, can you please provide more information about the strategic plan you are developing and what goals you hope to accomplish?

The TA we offer is flexible and tailored to whatever questions, ideas, or challenges you've got. Some examples of what we've done for other organizations (e.g.: hospitals, HIINs, health plans, QIN-QIOs, national and local provider associations and groups, and FQHCs and clinics) are:

- Help you draft or improve a strategic plan for your organization to address disparities over a few years with full support of your leadership, board, and staff (e.g.: a 5 year equity plan)
- Help you start thinking about your data and how to identify a particular disparity to focus on
- Help you find possible solutions to address a disparity you've identified – e.g.: an intervention for a particular population, training modules, and other strategies to improve the ability of your workforce to effectively treat the patients you serve
- Help you draft a CMS Disparities Impact Statement to structure your disparities work using a quality improvement approach and a PDSA cycle
- Help you draft a Language Access Plan to help your organization ensure you are addressing all of your patients' communication needs in a culturally appropriate and competent way
- Help you consider the physical accessibility, equipment, and training of staff in your clinical environment to ensure individuals with physical access challenges are able to get the care they need
- Help you find general or specific (depending on what you need) information, resources, and CMS data to help you address disparities in the population you serve

The first step is usually that we'd set up a time to talk with you for 30 minutes about what you're thinking of, so if you're interested in chatting please let us know and share a few dates/times that might work in your schedule. We are happy to chat!

I've also attached a two-pager that describes a bit more about our TA, how it works and what we offer. We also have a number of resources posted on our Health Equity TA website at go.cms.gov/healthequityTA, which we hope you will find helpful.

Thank you again for emailing – and for your work in helping to address health disparities!

Health Equity Technical Assistance Team

HealthEquityTA@cms.hhs.gov

CMS Office of Minority Health

Visit us at [\[go.cms.gov/healthequityTA\]](https://go.cms.gov/healthequityTA)go.cms.gov/healthequityTA



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From: Thomas, Andrew <Andrew.Thomas@RWJBH.org>
Sent: Wednesday, November 2, 2022 2:58 PM
To: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>
Subject: Help Needed

We are working on our Health Equity Strategic Plan and would appreciate any technical assistance we can get.

I am available for further discussions as your schedule permits.

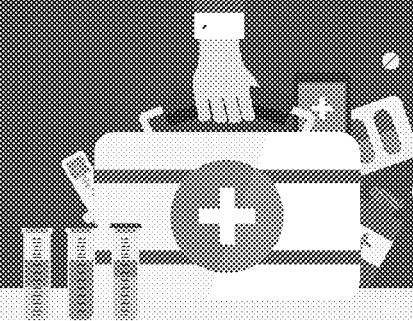
Best regards

Andrew J Thomas | Vice President of Health Equity, SICI
RWJBarnabas Health | 95 Old Short Hills Road | West Orange | NJ 07052
☎ 609.529.8130 | ✉ andrew.thomas@rwjbh.org



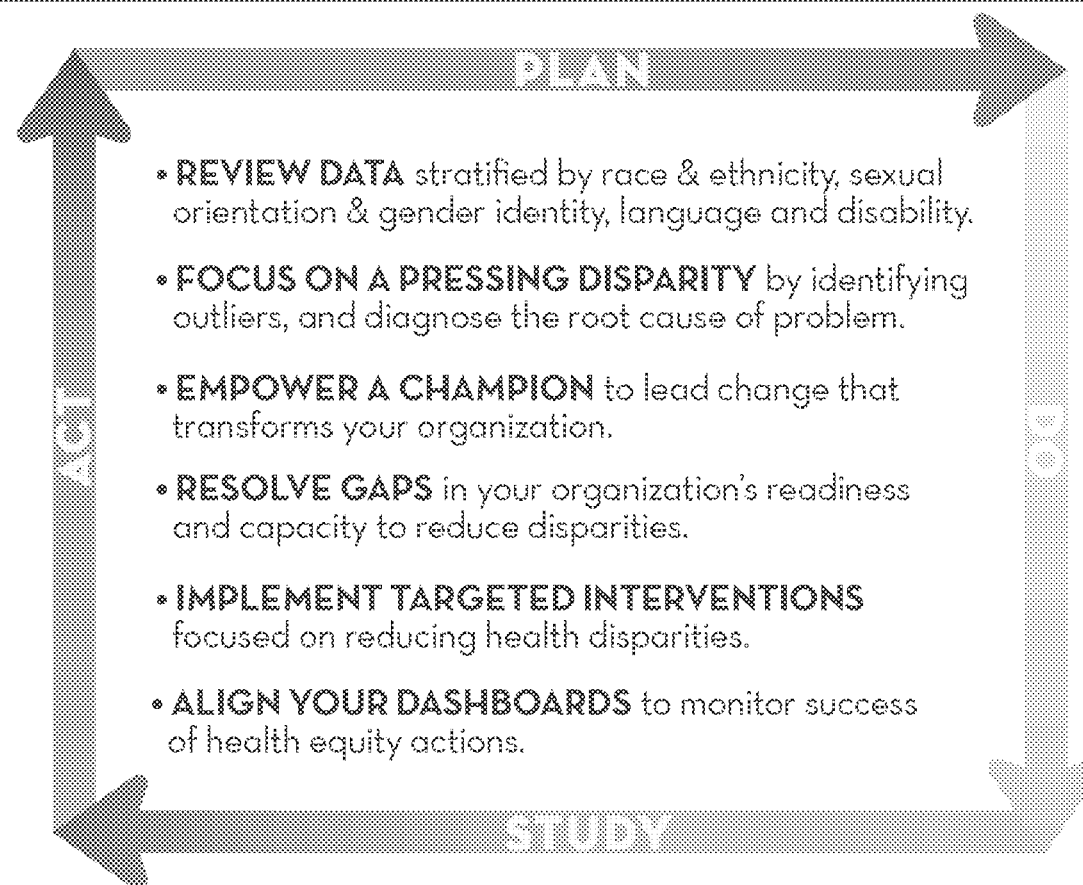
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BUILDING AN ORGANIZATIONAL RESPONSE TO HEALTH DISPARITIES



HEALTH EQUITY TECHNICAL ASSISTANCE

Learn how to **identify, prioritize, and take action** on health disparities in your organization. Participants receive personalized technical assistance focused on strengthening your quality improvement program through a series of consultations from subject matter experts. Contact us at HealthEquityTA@cms.hhs.gov to schedule a technical assistance consult and learn how to:



Health disparities are differences in health outcomes closely linked with social, economic, and environmental disadvantage – are often driven by the social conditions in which individuals live, learn, work, and play. Characteristics including race, ethnicity, disability, sexual orientation or gender identity, socio-economic status, geographic location, and other factors historically linked to exclusion or discrimination are associated with the health of individuals, families, and communities.

TECHNICAL ASSISTANCE: HOW WE HELP YOU IMPROVE

CONSULT 1



IDENTIFY
HEALTH
DISPARITIES

SET SMART
AIMS

CONSULT 2

IDENTIFY
GAPS

REVIEW
STRATIFIED
DASHBOARD

ADAPT
SOLUTIONS

CONSULT 3

EVALUATE
SUCCESS

SHARE
INSIGHTS

SUSTAIN
ACTION

PDSA

PDSA



“Working to Achieve Health Equity”

From: CMS Health Equity TA
To: Caitlin R Gardner
Cc: Phoebe Lamuda; Mollie Hertel (Hertel-Mollie@norc.org)
Subject: Re: Information on technical assistance
Date: Monday, April 24, 2023 2:44:48 PM
Attachments: image001.png

Great, talk soon!

From: Caitlin R Gardner <cgardner1@mvhospital.net>
Sent: Monday, April 24, 2023 2:42 PM
To: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>
Subject: RE: Information on technical assistance

I hadn't received it. Perfect, will see you on Zoom then.

From: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>
Sent: Monday, April 24, 2023 12:42 PM
To: Caitlin R Gardner <cgardner1@mvhospital.net>
Cc: Amber Wray <awray@mvhospital.net>
Subject: [External Email] Re: Information on technical assistance

Hi Caitlin,

I sent an invite, did you not receive it? Here is the zoom info below for the 3:30 call:

Join Zoom Meeting
<https://norc.zoom.us/j/86767291851>

Meeting ID: 867 6729 1851

One tap mobile
+13017158592,,86767291851# US (Washington DC)
+16469313860,,86767291851# US

Dial by your location
+1 301 715 8592 US (Washington DC)
+1 646 931 3860 US
+1 305 224 1968 US
+1 309 205 3325 US
+1 312 626 6799 US (Chicago)
+1 646 558 8656 US (New York)
+1 346 248 7799 US (Houston)
+1 360 209 5623 US
+1 386 347 5053 US
+1 507 473 4847 US
+1 564 217 2000 US

+1 669 444 9171 US
+1 669 900 6833 US (San Jose)
+1 689 278 1000 US
+1 719 359 4580 US
+1 253 205 0468 US
+1 253 215 8782 US (Tacoma)
877 853 5247 US Toll-free
888 788 0099 US Toll-free
833 548 0276 US Toll-free
833 548 0282 US Toll-free
833 928 4608 US Toll-free
833 928 4609 US Toll-free
833 928 4610 US Toll-free

Meeting ID: 867 6729 1851

Find your local number: <https://norc.zoom.us/j/kpxMrwNNr>

Join by SIP

86767291851@zoomcrc.com

From: Caitlin R Gardner <cgardner1@mvhospital.net>

Sent: Monday, April 24, 2023 2:11 PM

To: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>

Cc: Amber Wray <awray@mvhospital.net>

Subject: FW: Information on technical assistance

From: Caitlin R Gardner <cgardner1@mvhospital.net>

Sent: Monday, April 24, 2023 12:11 PM

To: Caitlin R Gardner <cgardner1@mvhospital.net>

Subject: RE: Information on technical assistance

Hi Phoebe,

Just wanted to confirm our phone meeting today at 3:30pm. Please call 208-542-7008

Thank you

From: Caitlin R Gardner

Sent: Thursday, April 20, 2023 10:20 AM

To: 'CMS Health Equity TA' <HealthEquityTA@cms.hhs.gov>

Subject: RE: Information on technical assistance

Yes, let's do: Monday at 3:30 to 4pm EDT

I look forward to speaking with you.

From: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>
Sent: Wednesday, April 19, 2023 3:24 PM
To: Caitlin R Gardner <cgardner1@myhospital.net>
Subject: [External Email] Re: Information on technical assistance

Hi Caitlin,

Just confirmed some today! Are you available during these dates and times for a 30-minute conversation?

- Monday: 4/24 3-3:30, 3:30-4 PM EDT
- Tuesday: 4/25 12:30 – 1 PM EDT

Thank you,

Phoebe on behalf of Health Equity TA Team

From: Caitlin R Gardner <cgardner1@myhospital.net>
Sent: Wednesday, April 19, 2023 12:54 PM
To: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>
Subject: RE: Information on technical assistance

Hi Phoebe,

Any update on availability of TA team? Please send me over any date and times you have and I will make it work.

Thank you, hope you are having a wonderful day.

From: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>
Sent: Thursday, March 30, 2023 11:13 AM
To: Caitlin R Gardner <cgardner1@myhospital.net>
Subject: [External Email] Re: Information on technical assistance

Dear Caitlin,

Unfortunately the TA team is not available for a call next week. I will look and confirm CMS OMH calendar times and send them over to you.

Thank you,

Phoebe on behalf of TA team

From: Caitlin R Gardner <cgardner1@myhospital.net>
Sent: Thursday, March 30, 2023 11:51 AM
To: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>

Subject: RE: Information on technical assistance

Good morning,

Thank you for your response. I would really appreciate some guidance on how to make our health equity initiative successful for our organization. Especially, what types of data to track, strategic plans (both short and long term), and drafting a CMS Disparities Impact Statement. We have made strides in health equity, but would love some guidance on improving.

I am available next week, Monday April 3rd 10am – 4pm, Tuesday April 4th 1pm – 4pm, Wednesday April 5th 9am -4pm, Thursday April 6th 9am-4pm and Friday April 7th 9am – 11am.

Please let me know if you need further available dates, my schedule is pretty open Mon – Fri, so let me know what works for you.

Thank you, and I look forward to discussing our health equity journey with you.

Caitlin Gardner BSN, RN
Health Equity Coordinator
Mountain View Hospital/Idaho Falls Community Hospital
208-542-4244
Cgardner1@mvhospital.net

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From: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>

Sent: Wednesday, March 29, 2023 11:12 AM

To: Caitlin R Gardner <cgardner1@mvhospital.net>

Subject: [External Email] Re: Information on technical assistance

Dear Caitlin,

Thank you for contacting the CMS Health Equity Technical Assistance Program. The TA we offer is flexible and tailored to whatever questions, ideas, or challenges you've got. Some examples of what we've done for other organizations (e.g.: hospitals, HIINs, health plans, QIN-QIOs, national and local provider associations and groups, and FQHCs and clinics) are:

- Help you draft or improve a strategic plan for your organization to address disparities over a few years with full support of your leadership, board, and staff (e.g.: a 5 year equity plan)
- Help you start thinking about your data and how to identify a particular disparity to focus on
- Help you find possible solutions to address a disparity you've identified – e.g.: an

intervention for a particular population, training modules, and other strategies to improve the ability of your workforce to effectively treat the patients you serve

- Help you draft a CMS Disparities Impact Statement to structure your disparities work using a quality improvement approach and a PDSA cycle
- Help you draft a Language Access Plan to help your organization ensure you are addressing all of your patients' communication needs in a culturally appropriate and competent way
- Help you consider the physical accessibility, equipment, and training of staff in your clinical environment to ensure individuals with physical access challenges are able to get the care they need
- Help you find general or specific (depending on what you need) information, resources, and CMS data to help you address disparities in the population you serve

The first step is usually that we'd set up a time to talk with you for 30 minutes about what you're thinking of, so if you're interested in chatting please let us know and share a few dates/times that might work in your schedule. We are happy to chat!

I've also attached a two-pager that describes a bit more about our TA, how it works and what we offer. We also have a number of resources posted on our Health Equity TA website at go.cms.gov/healthequityTA, which we hope you will find helpful.

Thank you again for emailing – and for your work in helping to address health disparities!
We look forward to working with you!

Health Equity Technical Assistance Team

HealthEquityTA@cms.hhs.gov

CMS Office of Minority Health

Visit us at [go.cms.gov/healthequityTA]go.cms.gov/healthequityTA



"Working to Achieve Health Equity"

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From: Caitlin R Gardner <cgardner1@myhospital.net>

Sent: Thursday, March 23, 2023 12:20 PM

To: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>

Subject: Information on technical assistance

Hi,

I would like any information you have in regards to technical assistance programs for our organization in regards to health equity.

Thank you,

Caitlin Gardner BSN, RN
Health Equity Coordinator
Mountain View Hospital/Idaho Falls Community Hospital
208-542-4244
Cgardner1@mvhospital.net

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557-2705.



“Working to Achieve Health Equity”

From: [CMS Health Equity TA](#)
To: [Bethea, Amber D](#)
Subject: Re: Interest in championing the Disparities Impact Statement
Date: Friday, January 14, 2022 4:35:33 PM
Attachments: [image001.png](#)
[Outlook-0oey03tx.png](#)

Dear Ms. Bethea,

Thank you for contacting the CMS Health Equity Technical Assistance Team. The TA we offer is flexible and tailored to whatever questions, ideas, or challenges your organization is facing. We're happy to talk with you about how to address the disparities you've identified in your patient population.

Some examples of what we've done for other organizations (e.g.: hospitals, HIINs, health plans, QIN-QIOs, national and local provider associations and groups, and FQHCs and clinics) are:

- Help you draft or improve a strategic plan for your organization to address disparities over a few years with full support of your leadership, board, and staff (e.g.: a 5 year equity plan)
- Help you start thinking about your data and how to identify a particular disparity to focus on
- Help you find possible solutions to address a disparity you've identified – e.g.: an intervention for a particular population, training modules, and other strategies to improve the ability of your workforce to effectively treat the patients you serve
- Help you draft a CMS Disparities Impact Statement to structure your disparities work using a quality improvement approach and a PDSA cycle
- Help you draft a Language Access Plan to help your organization ensure you are addressing all of your patients' communication needs in a culturally appropriate and competent way
- Help you consider the physical accessibility, equipment, and training of staff in your clinical environment to ensure individuals with physical access challenges are able to get the care they need
- Help you find general or specific (depending on what you need) information, resources, and CMS data to help you address disparities in the population you serve

We also have a number of resources posted on our Health Equity TA website at go.cms.gov/healthequityTA, which we hope you will find helpful. If you'd like to talk further, we can schedule a 30 minute meeting to talk about your work and next steps. Please let us know of days/times that you are available for a call.

Thank you again for emailing – and for your work in helping to address health disparities.

Health Equity Technical Assistance Team

HealthEquityTA@cms.hhs.gov

CMS Office of Minority Health

Visit us at [go.cms.gov/healthequityTA]go.cms.gov/healthequityTA



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From: Bethea, Amber D <Amber.Bethea@BSWHealth.org>
Sent: Monday, January 10, 2022 1:40 PM
To: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>
Cc: Bethea, Amber D <Amber.Bethea@BSWHealth.org>
Subject: Interest in championing the Disparities Impact Statement

We just launched our HTN Center last week and I want to ensure that our organization is able to identify, prioritize and take action on health disparities that are impacting our patients with uncontrolled blood pressure. I am interested in the personalized coaching and resources that your program has to offer. Please let me know next steps, Amber

Amber D. Bethea, PA-C, MBA

Practice Administrator- Advanced Practice Providers

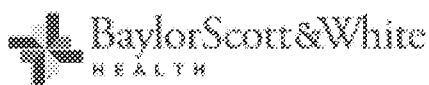
Business Development Lead

Baylor Scott & White Heart and Vascular Hospital – Dallas

621 N. Hall St. | Dallas, TX 75226

214-244-1183 Cell

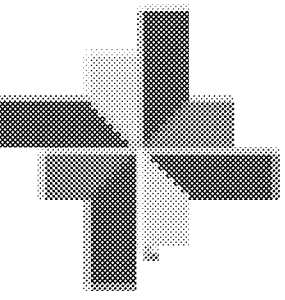
[BaylorHeartHospital.com](https://www.baylorheart.com) | [BaylorHeartCenter App](#) | [LinkedIn](#) [amberbethea](#)



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Baylor Scott & White
HEALTH



“Working to Achieve Health Equity”

From: [CMS Health Equity TA](#)
To: [Campbell, Karen](#)
Subject: Re: Looking for a survey/tool to measure any organization's Health Equity preparedness
Date: Tuesday, December 12, 2023 4:34:06 PM
Attachments: [Outlook-sx0uigxh.png](#)
[image.png](#)
[Outlook-ock1lboxl.png](#)
[image.png](#)

Dear Karen,

Thank you for sharing the additional information. It sounds like one of your goals is to understand health equity, particularly as it relates to nutrition and physical activity among community members with the goal of increasing health equity through your various programs. You may be able to answer your questions by assessing health outcomes pre and post the programs. To help you identify which health disparities you want to target (e.g., % of population with access to fresh food, or % of population with 4 days with 30 minutes of physical activity), the CMS-developed [Disparities Impact Statement worksheet](#) may be helpful. The worksheet walks you through five steps, starting with identifying the disparity, then defining your goals, establishing your health equity strategy, an action plan, and setting up how you will monitor and evaluate your progress.

Here is additional information and guidance on how to think through a disparities impact statement:

1. [HHS OMH Disparity Impact Strategy](#): provides an overview of HHS OMH's strategy and guidance for grantees to complete a DIS.
2. [ASPE In-depth equity assessment guide](#): This tool describes how to conduct intensive equity assessments of existing programs, policies, and processes. It is not identical to the DIS but follows a similar process and may be another useful way to think about your health disparities statement.
 - a. <https://aspe.hhs.gov/reports/equity-assessment-tip-sheet>: This provides tips on completing each of the 6 steps of the equity assessment.

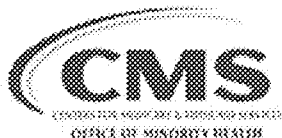
Thank you for your work advancing health equity,

Health Equity Technical Assistance Team

HealthEquityTA@cms.hhs.gov

CMS Office of Minority Health

Visit us at [\[go.cms.gov/healthequityTA\]](https://go.cms.gov/healthequityTA)go.cms.gov/healthequityTA



"Working to Achieve Health Equity"

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From: Campbell, Karren <camp1142@msu.edu>

Sent: Monday, October 23, 2023 2:43 PM

To: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>

Subject: Re: Looking for a survey/tool to measure any organization's Health Equity preparedness

Hello and thank you for your quick reply!

My apologies for omitting such essential information.

My request is for a project to improve health inequities for community residents through healthy nutrition and increased opportunities for physical activity. We are partnering with up to 10 community organizations (e.g., food pantries, mobile food markets, and those providing safe breastfeeding rooms, and safe streets and routes).

We are just beginning the work and need a pre-post assessment of health equity that will not be an undue burden on these community partners (who are not researchers and have limited time and resources).

Thank you for your guidance and please let me know if you have any questions,

Karren

Karren Campbell, PhD
Faculty Research Specialist
Department of Public Health
College of Human Medicine
Michigan State University
200 East 1st Street, Room 235 WS4
Flint, MI 48502
Phone: 810-600-5670, Ext. 7-5670
Email: camp1142@msu.edu

MICHIGAN STATE
UNIVERSITY

HURLEY
CHILDREN'S
HOSPITAL

PEDIATRIC PUBLIC HEALTH INITIATIVE

From: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>
Sent: Monday, October 23, 2023 1:28 PM
To: Campbell, Karren <camp1142@msu.edu>
Subject: Re: Looking for a survey/tool to measure any organization's Health Equity preparedness

Dear Karen,

Thank you for reaching out to the CMS Health Equity Technical Assistance mailbox. To better understand the kind of scales that may be useful, can you share a little more about the context in which you are trying to assess health equity? For example are you interesting assessing health equity within a community, a health services organization, etc.?

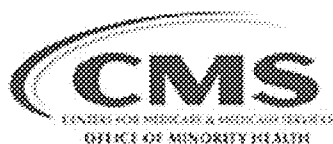
Thank you for your work advancing health equity,

Health Equity Technical Assistance Team

HealthEquityTA@cms.hhs.gov

CMS Office of Minority Health

Visit us at go.cms.gov/healthequityTA



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From: Campbell, Karren <camp1142@msu.edu>
Sent: Tuesday, October 17, 2023 1:54 PM
To: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>
Subject: Looking for a survey/tool to measure any organization's Health Equity preparedness

Greeting,

I have been having difficulty finding any well established measures of Health Equity. I would prefer evidence-based measures that have established validity and reliability.

The only measures I have found have been very very long and not suitable for practical, real world use with small community based organizations run by people with huge hearts but not a lot of time or research savvy.

I would appreciate it if you could recommend any high quality Health Equity assessment tools (even if they do not meet all of my "preferred" criteria).

Thank you in advance,

Karren

Karren Campbell, PhD
Faculty Research Specialist
Department of Public Health
College of Human Medicine
Michigan State University
200 East 1st Street, Room 235 WS4
Flint, MI 48502
Phone: 810-600-5670, Ext. 7-5670
Email: camp1142@msu.edu



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“Working to Achieve Health Equity”

From: CMS Health Equity TA
To: Randee M. Jackson
Cc: Brittany T. Oliva Ramey; Corina Falcon
Subject: Re: Looking for assistance
Date: Thursday, November 3, 2022 5:51:11 PM
Attachments: image001.png
image002.png
image003.png
image004.png
image005.png
Technical Assistance.pdf
Outlook-hfg0hlgo.png

Dear Randee,

Thank you for contacting the CMS Health Equity Technical Assistance Program. The TA we offer is flexible and tailored to whatever questions, ideas, or challenges you've got. Some examples of what we've done for other organizations (e.g.: hospitals, HIINs, health plans, QIN-QIOs, national and local provider associations and groups, and FQHCs and clinics) are:

- Help you draft or improve a strategic plan for your organization to address disparities over a few years with full support of your leadership, board, and staff (e.g.: a 5 year equity plan)
- Help you start thinking about your data and how to identify a particular disparity to focus on
- Help you find possible solutions to address a disparity you've identified – e.g.: an intervention for a particular population, training modules, and other strategies to improve the ability of your workforce to effectively treat the patients you serve
- Help you draft a CMS Disparities Impact Statement to structure your disparities work using a quality improvement approach and a PDSA cycle
- Help you draft a Language Access Plan to help your organization ensure you are addressing all of your patients' communication needs in a culturally appropriate and competent way
- Help you consider the physical accessibility, equipment, and training of staff in your clinical environment to ensure individuals with physical access challenges are able to get the care they need
- Help you find general or specific (depending on what you need) information, resources, and CMS data to help you address disparities in the population you serve

Below are some resources on Z codes and SDOH screening tools that may be useful for your initiative.

- o CMS has released a Guide to using the AHC Health-Related Social Needs Screening Tool (and other screening tools for social risk factors), which includes insight into how to implement screening for SDOH and social risk factors, what to ask, and how to integrate screening into a practice so that the information can be used to improve health and health care. Appendix D also has an overview of other screening tools.
- o For SDOH Z codes, please refer to Chapter 21, Section 17 Social Determinants of Health, in the *FY 2023 ICD-10-CM Official Guidelines for Coding and Reporting* (<https://www.cms.gov/files/document/fy-2023-icd-10-cm-coding-guidelines.pdf>)
- o CMS MACBIS T-MSIS Reporting Reminder: Reporting ICD-10-CM Diagnosis Codes with clarification on "Z Codes" for Social Determinants of Health (SDOH), states that: "States

should report diagnosis codes in T-MSIS in the order that they come in on the claim. States should report as many diagnosis codes as the T-MSIS architecture allows.” As required diagnosis codes for States, this data should be safeguarded, exchanged, and otherwise managed in ways consistent with 42 CFR 433.138(e), (g), and (h), which describe the requirements for diagnosis and trauma codes and discuss safeguarding information, citing data agreements related to exchange, use, provision, protection, and disclosure of information (<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-433/subpart-D>).

- Your state may have additional guidance, resources, or best practices on this topic and we encourage you to reach out to state-level agencies regulating third party billing.
- While there isn’t a Z code for screening itself or a specific screening tool, social determinants of health (SDOH) can be very important factors in patient health, risk, and health outcomes. CMS Office of Minority Health (OMH) has released an [Infographic](#) to help providers, coding professionals, and health care administrators who are interested in collecting SDOH information using ICD-10-CM SDOH Z codes. The infographic includes information on SDOH and Z codes, as well as resources on best practices to help organizations use Z codes to improve health outcomes among their patients.
- There is also an [existing resource](#) from CMS OMH that may be useful as your organization considers ways to improve quality, care coordination, and experience of care using social determinants of health.
- Additionally, The National Center for Health Statistics ICD-10-CM Browser tool is located at <https://icd10cmtool.cdc.gov/>. This user-friendly web-based query application allows users to search for codes from the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) and provides instructional information needed to understand the usage of ICD-10-CM codes.

The first step is usually that we’d set up a time to talk with you for 30 minutes about what you’re thinking of, so if you’re interested in chatting please let us know and share a few dates/times that might work in your schedule. We are happy to chat!

I’ve also attached a two-pager that describes a bit more about our TA, how it works and what we offer. We also have a number of resources posted on our Health Equity TA website at go.cms.gov/healthequityTA, which we hope you will find helpful.

Thank you again for emailing – and for your work in helping to address health disparities! We look forward to working with you!

Health Equity Technical Assistance Team

HealthEquityTA@cms.hhs.gov

CMS Office of Minority Health

Visit us at [go.cms.gov/healthequityTA]go.cms.gov/healthequityTA



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From: Randee M. Jackson <r.jackson@dhr-rgv.com>
Sent: Wednesday, October 19, 2022 12:35 PM
To: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>
Cc: Brittany T Oliva Ramey <b.oliva@dhr-rgv.com>; Corina Falcon <co.falcon@dhr-rgv.com>
Subject: Looking for assistance

Good afternoon,

I am inquiring about the CMS OMH Health Equity Technical Assistance Program. I have been reading the information provided online and feeling a little overwhelmed about the whole process. Doctors Hospital at Renaissance is a physician owned hospital. We are not a corporation and initiatives like these are home grown. I have begun creating a screening tool for identifying SDOH disparities in relation to the correlating z codes. My social worker supervisor is preparing resources.

Kindly requesting assistance to help DHR get off the ground with this initiative. I need to create a committee involving whoever else within the hospital needs to assist like Quality, Data analysts, etc. We need to develop a strategic plan, but I do not know where to start.

Thank you,
Randee Jackson

Randee Jackson RN

Director of Resource Management

o. 956-362-7191

5501 S. McColl Rd.

f. 956-362-6266

Edinburg, TX 78539

c. 956-280-9037

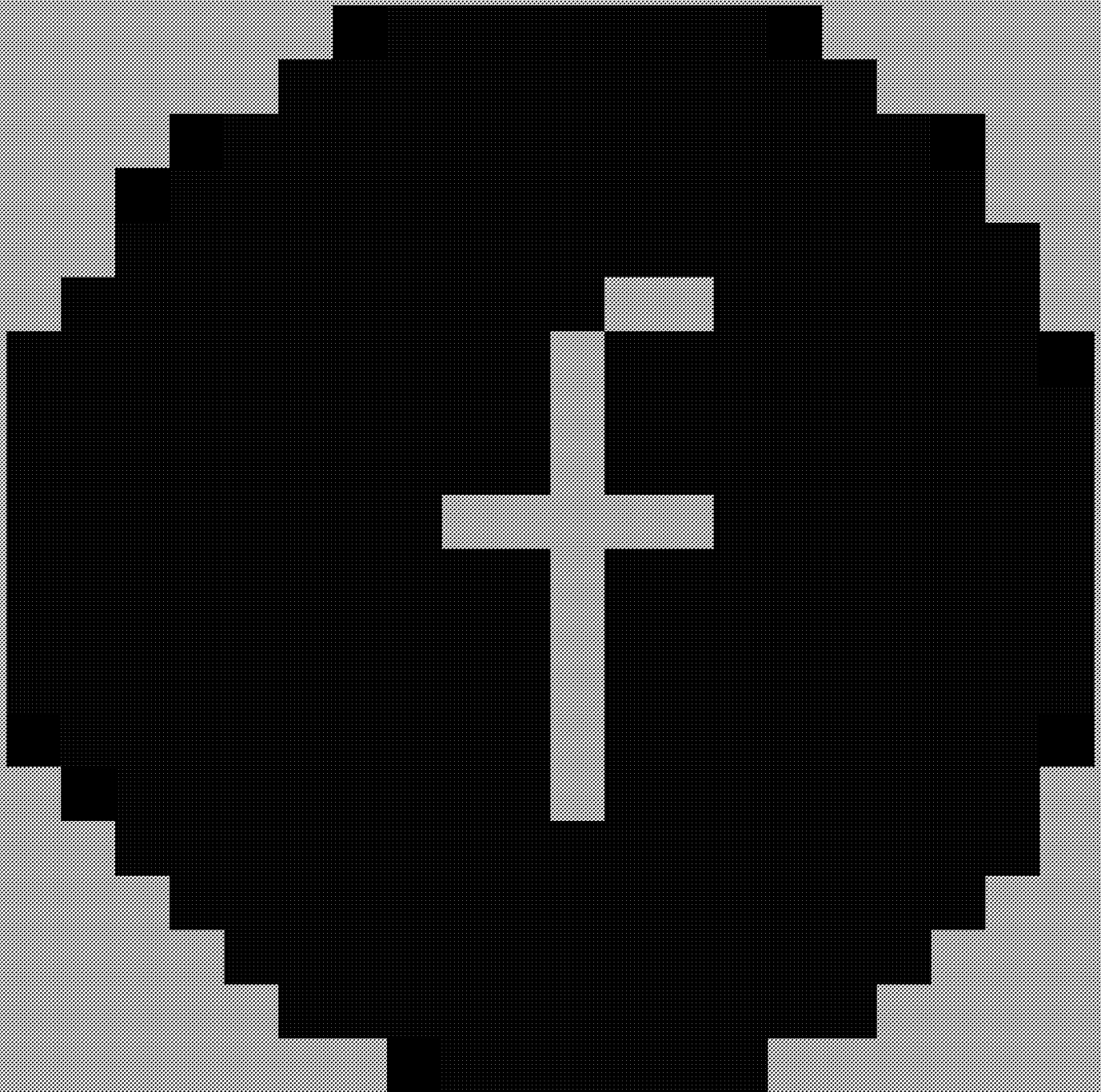


DHR Health

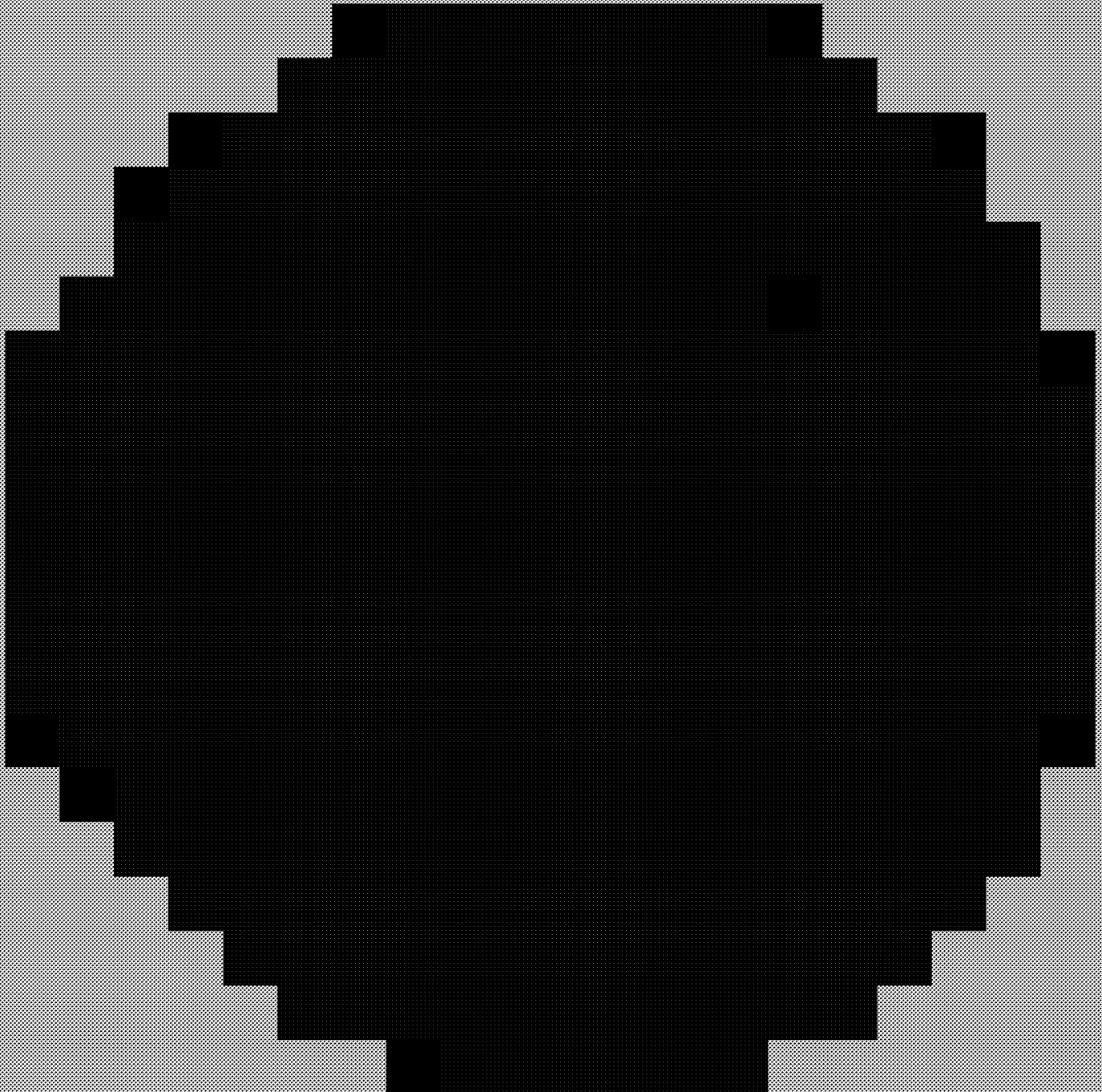


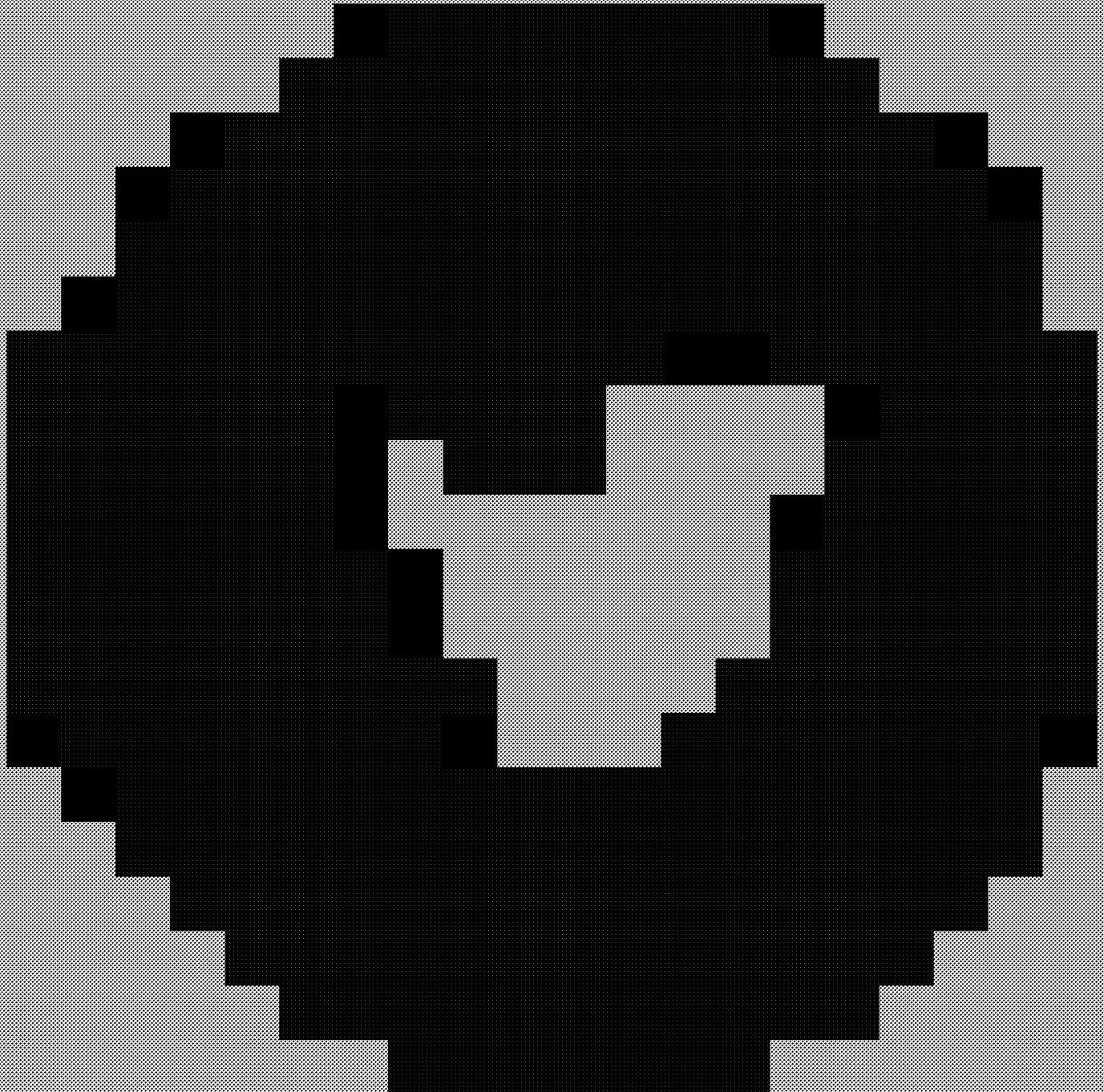
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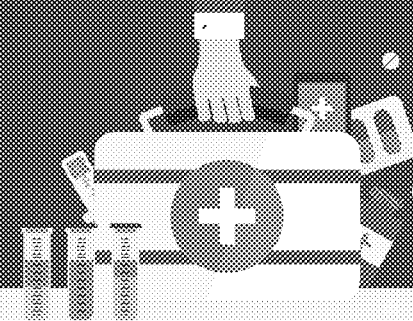






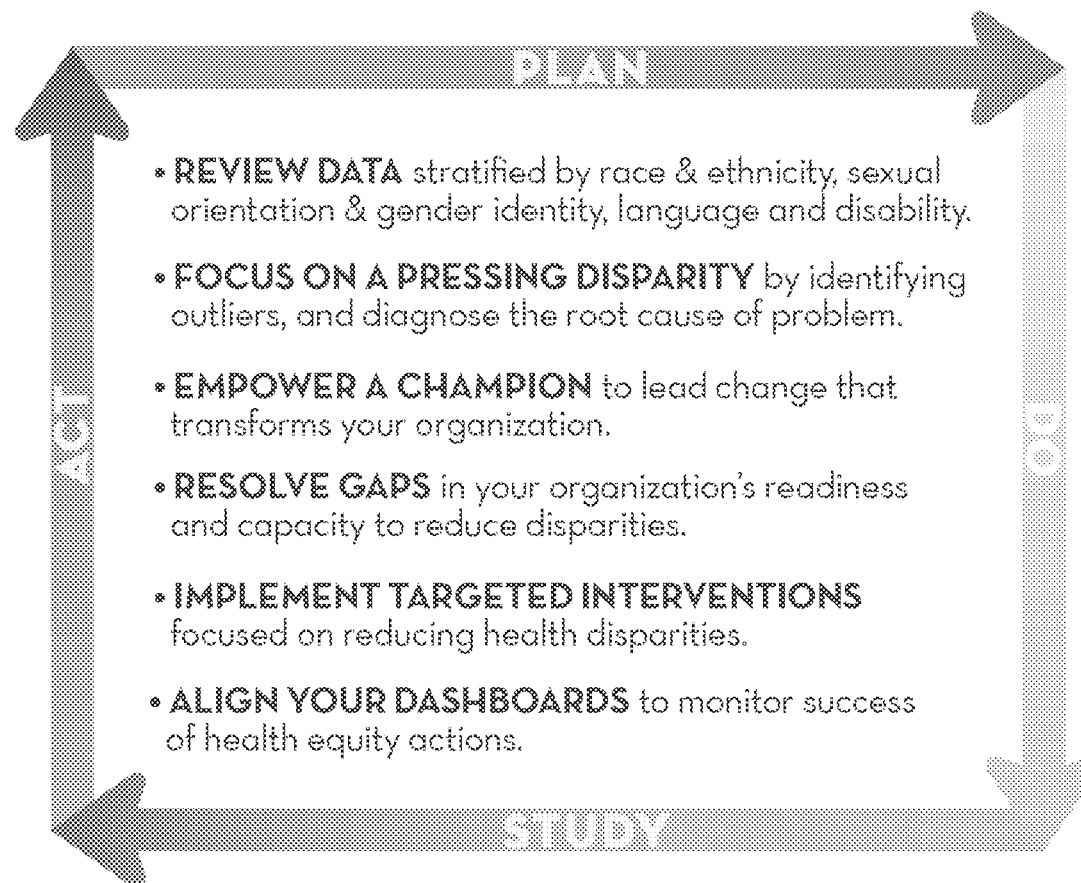


BUILDING AN ORGANIZATIONAL RESPONSE TO HEALTH DISPARITIES



HEALTH EQUITY TECHNICAL ASSISTANCE

Learn how to **identify, prioritize, and take action** on health disparities in your organization. Participants receive personalized technical assistance focused on strengthening your quality improvement program through a series of consultations from subject matter experts. Contact us at HealthEquityTA@cms.hhs.gov to schedule a technical assistance consult and learn how to:



Health disparities are differences in health outcomes closely linked with social, economic, and environmental disadvantage – are often driven by the social conditions in which individuals live, learn, work, and play. Characteristics including race, ethnicity, disability, sexual orientation or gender identity, socio-economic status, geographic location, and other factors historically linked to exclusion or discrimination are associated with the health of individuals, families, and communities.

TECHNICAL ASSISTANCE: HOW WE HELP YOU IMPROVE

CONSULT 1



IDENTIFY
HEALTH
DISPARITIES

SET SMART
AIMS

CONSULT 2

IDENTIFY
GAPS

REVIEW
STRATIFIED
DASHBOARD

PDSA

ADAPT
SOLUTIONS

PDSA

CONSULT 3

EVALUATE
SUCCESS

SHARE
INSIGHTS

SUSTAIN
ACTION



“Working to Achieve Health Equity”

From: [CMS Health Equity TA](#)
To: [LuAnne Brown](#)
Subject: Re: Need some assistance with Disparities Impact Statement
Date: Friday, July 14, 2023 5:14:48 PM
Attachments: [image001.png](#)
[image003.png](#)
[image004.png](#)
[image.png](#)

Dear LuAnne,

Thank you for reaching out to the Health Equity TA team. CMS developed a [Disparities Impact Statement \(DIS\) resource](#). You may find it helpful to walk through this brief worksheet to create a DIS. If you're looking for additional information and guidance please see the following resources:

- [HHS OMH Disparity Impact Strategy](#): provides an overview of HHS OMH's strategy and guidance for grantees to complete a DIS.
- [ASPE In-depth equity assessment guide](#): This tool describes how to conduct intensive equity assessments of existing programs, policies, and processes. It is not identical to the DIS but follows a similar process and may be another useful way to think about your health disparities statement.
 - <https://aspe.hhs.gov/reports/equity-assessment-tip-sheet>: This provides tips on completing each of the 6 steps of the equity assessment.

Thank you for your work advancing health equity,

Health Equity Technical Assistance Team

HealthEquityTA@cms.hhs.gov

CMS Office of Minority Health

Visit us at [\[go.cms.gov/healthequityTA\]](https://go.cms.gov/healthequityTA)go.cms.gov/healthequityTA



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From: LuAnne Brown <lb@bppn.org>
Sent: Monday, July 10, 2023 3:39 PM
To: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>
Subject: RE: Need some assistance with Disparities Impact Statement

LuAnne Brown, RN
(She,her,hers Why pronouns matter)
CEO
Buffalo Prenatal Perinatal Network
703 Washington Street
Buffalo, NY 14203
lb@bppn.org
(716)884-6711 Ext. 1006
Fax (716)884-0513
Website: <http://www.bppn.org>

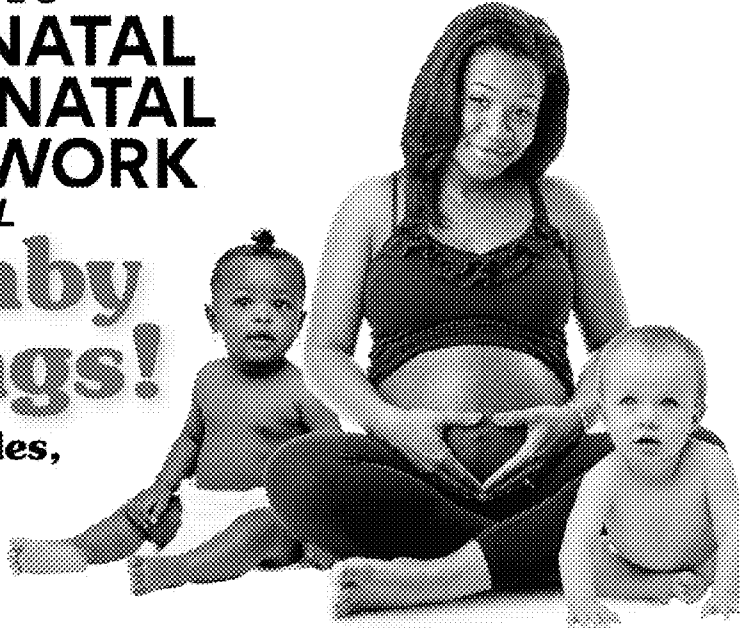


BUFFALO PRENATAL PERINATAL NETWORK

THE 20TH ANNUAL

Great Baby Beginnings!

**Cocktails, Dinner, Raffles,
Auctions, and Program**
Wednesday, July 19 2023
5:00 P.M. - 8:00 P.M.
at The Foundry



Two Ticket Options:

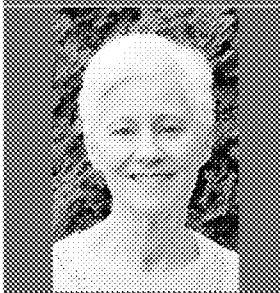
\$85 in person event that includes cocktails, dinner, auctions, raffles, and program.

\$30 virtual ticket that includes access to the silent auction & some raffles & streaming link for program.

Honorees



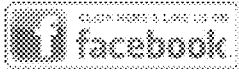
Mary K. Comtois, United Way
of Buffalo and Erie County



Caroline Novotny-Schulz, Buffalo
Children's Hospital



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"It is better to build strong children than to repair broken men"
Frederick Douglass



BUFFALO PRENATAL PERINATAL NETWORK

THE 20TH ANNUAL

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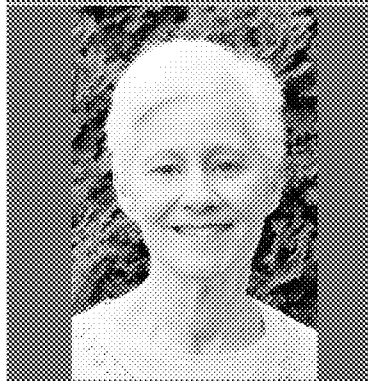
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Honorees

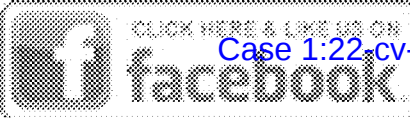


Mary K. Comtois, United Way
of Buffalo and Erie County



Caroline Novotny-Schulefand
MEdSR, RN, Osheset Children's Hospital







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“Working to Achieve Health Equity”

From: [Carey Lai](#)
To: [CMS Health Equity TA](#)
Subject: Re: Request for Collaboration and Assistance - Yohocare's Chatbot Project for Minority Seniors
Date: Wednesday, July 26, 2023 6:56:02 PM
Attachments: [image.png](#)

Greetings,

I hope this email finds you well and healthy. Thank you so much for your reply. I am available to meet on 8/2 (Wednesday) at 12:30 pm ET.

If you require any further information, please feel free to let me know.

Once again, thank you, and I am eagerly looking forward to hearing from you regarding the instructions for the call.

Warmly,
Carey

On Wed, Jul 26, 2023 at 3:38 PM CMS Health Equity TA <HealthEquityTA@cms.hhs.gov> wrote:

Hi Carey,

Thank you for reaching out to the CMS Health Equity Technical Assistance team. Our team has some time next week to chat and hear more about what you are doing and how CMS OMH may support your health equity efforts. Below are times the team is available for a 30-minute call, do any of these times work for you?

Tues 8/1: 11 AM – 12:00 PM ET ; 3-3:30 PM ET

Wed 8/2: 11 AM – 1 PM ET

Thank you for your work advancing health equity,

Health Equity Technical Assistance Team

HealthEquityTA@cms.hhs.gov

CMS Office of Minority Health

Visit us at [\[go.cms.gov/healthequityTA\]](https://go.cms.gov/healthequityTA) go.cms.gov/healthequityTA



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From: Carey Lai <carey@yohocare.com>

Sent: Tuesday, July 18, 2023 12:55 PM

To: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>

Cc: Carey Lai <carey@yohocare.com>

Subject: Request for Collaboration and Assistance - Yohocare's Chatbot Project for Minority Seniors

Greetings,

I hope this message finds you well. My name is Carey Lai, and I am the co-founder of Yohocare, a mission-driven startup focused on creating healthcare solutions that cater to all, especially the underrepresented populations.

We are currently working on an ambitious project to develop a culturally attuned chatbot dedicated to minority seniors. The primary aim of this endeavor is to bridge the gap in communication and accessibility of healthcare services, thereby aligning with our core value of inclusivity.

I recently had the opportunity to attend the 2023 CMS HL7 FHIR Connectathon, where I learned about the CMS Health Equity Technical Assistance Program. The initiative's vision and mission strongly resonate with our goals at Yohocare, and I believe it aligns perfectly with our ongoing project.

Upon visiting your website, I found that the resources and assistance your program provides could significantly support our developmental efforts. The prospects of personalized coaching, resources for embedding health equity into our strategic plan, data collection and analysis, and assistance in developing a language access plan are of particular interest to us. Furthermore, your focus on improving care for minority populations, including racial and ethnic minorities, people with disabilities, members of the LGBTQ+ community, individuals with limited English proficiency, and rural populations, is directly in line with the populations we aim to serve.

I am writing to explore how we could leverage the invaluable resources from your program to further our project and ensure its successful implementation. Your guidance and support could profoundly impact our efforts to make healthcare more accessible and inclusive.

We are open to setting up a meeting or a call at your earliest convenience to discuss how we can potentially collaborate. In the meantime, if there are any documents or applications we need to complete to move forward with this, please feel free to send them my way.

We look forward to the potential opportunity to work together and contribute to the much-needed change in our healthcare system.

Best Regards,

Carey Lai
Co-founder, Yohocare



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“Working to Achieve Health Equity”

From: [Carey Lai](#)
To: [CMS Health Equity TA](#)
Cc: [Bryden, Alexandra \(CMS/OMH\)](#); [Oswald, Michelle \(CMS/OMH\)](#); [Phoebe Lamuda](#); [Kelsey Besse](#); [Megan Coffman](#)
Subject: Re: Yohocare TA call
Date: Wednesday, August 2, 2023 2:33:15 PM

Dear Phoebe and TA team,

Thank you so much for sending me the valuable information and links. Your efforts have saved me a substantial amount of time and have been extremely helpful in my research/work.

Again, thank you so much and have a wonderful day.

Warmly,
Carey

On Wed, Aug 2, 2023 at 10:47 AM CMS Health Equity TA <HealthEquityTA@cms.hhs.gov> wrote:

Hi Carey,

Here are the links we provided during our conversation:

Disparities Impact Statement:

<https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Disparities-Impact-Statement-508-rev102018.pdf>

Language Access Plan:

<https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Language-Access-Plan-508.pdf>

CDC Preferred Terms:

https://www.cdc.gov/healthcommunication/Preferred_Terms.html



CDC's Health Equity Guiding Principles for Inclusive Communication

Inclusive language to reflect the needs of select population groups.

www.cdc.gov

Mini-Cog links:

<https://mini-cog.com/mini-cog-in-other-languages/>

<https://mini-cog.com/contact/>

How to Develop Products for Adults with Intellectual Developmental Disabilities and Extreme Low Literacy A Product Development Tool: <https://www.cdc.gov/ccindex/pdf/idd-ell-product-development-tool-508.pdf>

Recognizing Symptoms of Dementia and Seeking Help

<https://www.cdc.gov/aging/publications/features/dementia-not-normal-aging.html>

Materials translated by the CDC: <https://wwwn.cdc.gov/pubs/other-languages?Sort=Lang%3A%3Aasc&Language=Chinese%20Traditional>

We hope you find these helpful,
Phoebe on behalf of TA team

From: Carey Lai <carey@yohocare.com>

Sent: Wednesday, August 2, 2023 1:18 PM

To: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>

Cc: Bryden, Alexandra (CMS/OMH) <Alexandra.Bryden@cms.hhs.gov>; Oswald, Michelle (CMS/OMH) <Michelle.Oswald@cms.hhs.gov>; Phoebe Lamuda <lamuda-phoebe@norc.org>; Kelsey Besse <besse-kelsey@norc.org>; Megan Coffman <coffman-megan@norc.org>

Subject: Re: Yohocare TA call

Greetings,

I just wanted to say a BIG THANK YOU for taking the time to chat with me and for providing all those helpful links and pieces of information. I really appreciate it.

To ensure I don't miss anything, could you please share all the links with me once more? I plan to set aside time to thoroughly review this information. If I have any additional questions, I will get in touch with you.

Your kindness and assistance have truly made a significant difference for me, and I am incredibly grateful for your help.

Thank you once again and have a blessed day.

Warmly,
Carey

On Mon, Jul 31, 2023 at 6:33 AM CMS Health Equity TA <HealthEquityTA@cms.hhs.gov> wrote:

Topic: Yohocare and CMS OMH Call

Time: Aug 2, 2023 12:30 PM Eastern Time (US and Canada)

Join Zoom Meeting

<https://norc.zoom.us/j/81899335207>

Meeting ID: 818 9933 5207

Original email:

I hope this message finds you well. My name is Carey Lai, and I am the co-founder of Yohocare, a mission-driven startup focused on creating healthcare solutions that cater to all, especially the underrepresented populations.

We are currently working on an ambitious project to develop a culturally attuned chatbot dedicated to minority seniors. The primary aim of this endeavor is to bridge the gap in communication and accessibility of healthcare services, thereby aligning with our core value of inclusivity.

I recently had the opportunity to attend the 2023 CMS HL7 FHIR Connectathon, where I learned about the CMS Health Equity Technical Assistance Program. The initiative's vision and mission strongly resonate with our goals at Yohocare, and I believe it aligns perfectly with our ongoing project.

Upon visiting your website, I found that the resources and assistance your program provides could significantly support our developmental efforts. The prospects of personalized coaching, resources for embedding health equity into our strategic plan, data collection and analysis, and assistance in developing a language access plan are of particular interest to us. Furthermore, your focus on improving care for minority populations, including racial and ethnic minorities, people with disabilities, members of the LGBTQ+ community, individuals with limited English proficiency, and rural populations, is directly in line with the populations we aim to serve.

I am writing to explore how we could leverage the invaluable resources from your program to further our project and ensure its successful implementation. Your guidance and support could profoundly impact our efforts to make healthcare more accessible and inclusive.

We are open to setting up a meeting or a call at your earliest convenience to discuss how we can potentially collaborate. In the meantime, if there are any documents or applications we need to complete to move forward with this, please feel free to send them my way.

We look forward to the potential opportunity to work together and contribute to the much-needed change in our healthcare system.

One tap mobile

+16469313860,,81899335207# US

+13017158592,,81899335207# US (Washington DC)

Dial by your location

+1 646 931 3860 US
+1 301 715 8592 US (Washington DC)
+1 305 224 1968 US
+1 309 205 3325 US
+1 312 626 6799 US (Chicago)
+1 646 558 8656 US (New York)
+1 360 209 5623 US
+1 386 347 5053 US
+1 507 473 4847 US
+1 564 217 2000 US
+1 669 444 9171 US
+1 669 900 6833 US (San Jose)
+1 689 278 1000 US
+1 719 359 4580 US
+1 253 205 0468 US
+1 253 215 8782 US (Tacoma)
+1 346 248 7799 US (Houston)
833 928 4609 US Toll-free
833 928 4610 US Toll-free
877 853 5247 US Toll-free
888 788 0099 US Toll-free
833 548 0276 US Toll-free
833 548 0282 US Toll-free
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From: [CMS Health Equity TA](#)
To: [Christine Lau](#)
Subject: Re: Seeking assistance to ensure health equity for new company
Date: Wednesday, August 17, 2022 9:42:21 AM
Attachments: [Outlook-x5ufse5b.png](#)

Dear Christine,

Thank you for contacting the CMS Health Equity Technical Assistance Program. The TA we offer (at no cost) is flexible and tailored to whatever questions, ideas, or challenges you've got. Some examples of what we've done for other organizations (e.g.: hospitals, HIINs, health plans, QIN-QIOs, national and local provider associations and groups, and FQHCs and clinics) are:

- Help you draft or improve a strategic plan for your organization to address disparities over a few years with full support of your leadership, board, and staff (e.g.: a 5 year equity plan)
- Help you start thinking about your data and how to identify a particular disparity to focus on
- Help you find possible solutions to address a disparity you've identified – e.g.: an intervention for a particular population, training modules, and other strategies to improve the ability of your workforce to effectively treat the patients you serve
- Help you draft a CMS Disparities Impact Statement to structure your disparities work using a quality improvement approach and a PDSA cycle
- Help you draft a Language Access Plan to help your organization ensure you are addressing all of your patients' communication needs in a culturally appropriate and competent way
- Help you consider the physical accessibility, equipment, and training of staff in your clinical environment to ensure individuals with physical access challenges are able to get the care they need
- Help you find general or specific (depending on what you need) information, resources, and CMS data to help you address disparities in the population you serve

The first step is usually that we'd set up a time to talk with you for 30 minutes about what you're thinking of, so if you're interested in chatting please let us know and share a few dates/times that might work in your schedule. We are happy to chat!

We also have a number of resources posted on our [Health Equity TA website](#), which we hope you will find helpful.

We look forward to working with you!

Health Equity Technical Assistance Team

HealthEquityTA@cms.hhs.gov

CMS Office of Minority Health

Visit us at [\[go.cms.gov/healthequityTA\]](https://go.cms.gov/healthequityTA)go.cms.gov/healthequityTA



"Working to Achieve Health Equity"

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From: Christine Lau <clau@careallyhealth.com>
Sent: Tuesday, August 16, 2022 4:03 PM
To: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>
Subject: Seeking assistance to ensure health equity for new company

I am involved in a healthcare startup and key to our vision and purpose is health equity. I have the wonderful opportunity to build this company so that health equity is infused into our culture, reflected in our strategic plan, policies & procedures, staff hiring and training, outreach and marketing and services to those living with illness. I've been pouring through the rich content on the CMS website, and saw that technical assistance is available. We are committed to doing things right from the start and continually improving from there. I would love any guidance/coach that you can provide.

Thanks,
Christine

Christine Lau RN, LCSW, APHSW-C
SVP Product & Clinical Services
CareAlly Health
828-845-5158
Careallyhealth.com



“Working to Achieve Health Equity”

From: [CMS Health Equity TA](#)
To: [Alexander, Sharon \(2\)](#)
Subject: Re: Tools and resources
Date: Friday, February 18, 2022 10:55:39 AM
Attachments: [Outlook-xtibph2m.png](#)

Dear Sharon,

Thank you for contacting the CMS Health Equity Technical Assistance Team. The following resources may be helpful as you seek to promote health equity among the populations you serve.

- [CMS Disparities Impact Statement](#), which helps you learn how to identify, prioritize, and take action on health disparities.
- [Building an Organizational Response to Health Disparities – Resource Guide](#), which includes resources and concepts key to addressing disparities and improving health care quality throughout your organization.
- [Modernizing Health Care to Improve Physical Accessibility: Resources Inventory](#), which includes guidance on how to increase physical accessibility of medical services, tools to assess your practice or facility's accessibility, and tips and training materials to support efforts to reduce barriers and improve quality of care for individuals with disabilities.
- [Guide to Developing a Language Access Plan](#), which identifies ways that providers can assess their programs and develop language access plans to ensure persons with limited English proficiency have meaningful access to their programs.
- [Providing Language Services to Diverse Populations: Lessons from the Field](#), which discusses a number of approaches used by health care organizations to provide language assistance services to persons with limited English proficiency.
- [Medicare Learning Network web-based trainings](#), which are free, self-paced learning on a broad range of topics for health care providers.

Thank you for your work advancing health equity.

Sincerely,

Health Equity Technical Assistance Team

HealthEquityTA@cms.hhs.gov

CMS Office of Minority Health

Visit us at [\[go.cms.gov/healthequityTA\]](https://go.cms.gov/healthequityTA)go.cms.gov/healthequityTA



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From: Alexander, Sharon (2) <Sharon.Alexander@McKesson.com>

Sent: Monday, February 14, 2022 12:47 PM

To: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>

Subject: Tools and resources

Hello,

Would you be able to share any tools or resources for the MIPS Improvement Activity of Create and Implement an Anti-Racism Plan, please?

Thank you,
Sharon

Sharon Alexander

Value-Based Care Portfolio Manager | m 706.215.3090 | Sharon.Alexander@McKesson.com

The US Oncology Network | 10101 Woodloch Forest Dr., The Woodlands, TX 77380 | www.mckesson.com

Upcoming out of office dates: 2/8-10

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“Working to Achieve Health Equity”

From: غراب الغراب
To: CMS Health Equity TA
Subject: Re:
Date: Saturday, August 5, 2023 8:28:10 PM
Attachments: image.png
 image.png

Thank you for sharing this wonderful experience with me I understand that and I will not shears or give the lesson to anyone else. Thank you again for your great time in helping out the other. Thank God for your help

كتب: <HealthEquityTA@cms.hhs.gov> CMS Health Equity TA في الاثنين، ٣١ يوليو ٢٠٢٣ ٥:٠٨ م
 Hello,

Thank you for contacting the CMS Health Equity Technical Assistance Program. We appreciate your interest in health equity. On the CMS Health Equity Technical Assistance Program [webpage](#), you can find a number of resources that may be helpful in learning more about health equity.

Under the section Resources to Advance Equity, the Disparities Impact Statement will walk you through the process of identifying and plan how to address a disparity in your community. Under the Trainings section you will find a number of web-based trainings, videos, and files on a variety of topics. These resources are focused on the Medicare and Medicaid populations in the United States, but we hope you will find them useful in your work.

Thank you,

Health Equity Technical Assistance Team

HealthEquityTA@cms.hhs.gov

CMS Office of Minority Health

Visit us at [\[go.cms.gov/healthequityTA\]](https://go.cms.gov/healthequityTA) go.cms.gov/healthequityTA



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From: غراب الغراب <ghrabalghrab3@gmail.com>

Sent: Tuesday, July 11, 2023 5:58 PM

To: CMS Health Equity TA <HealthEquityTA@cms.hhs.gov>

Subject:

Thank you for your time. I am looking forward to be of your student in Health Equity.please give me the chance .



“Working to Achieve Health Equity”



“Working to Achieve Health Equity”

Quality Payment PROGRAM

Merit-based Incentive Payment System (MIPS)

**Participating in the Improvement
Activities Performance Category in the
2022 Performance Year: Traditional
MIPS**



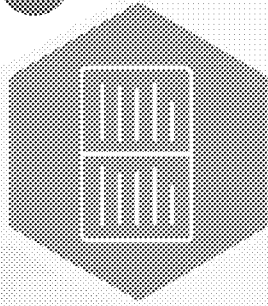
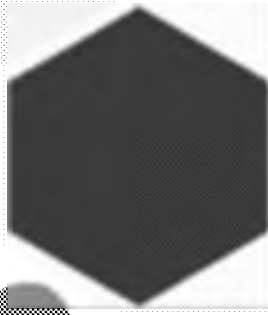
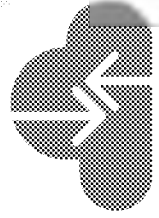
Contents

Already know what MIPS is?

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Purpose: This detailed resource focuses on the improvement activities performance category requirements under the traditional Merit-based Incentive Payment System (MIPS) (original framework for collecting and reporting data since the inception of the Quality Payment Program), including data collection and submission for individual, group, virtual group, and Alternative Payment Model (APM) Entity participation for the 2022 performance year. This resource doesn't address improvement activities requirements under the Alternative Payment Model Pathway (APP).



How to Use This Guide

How to Use This Guide

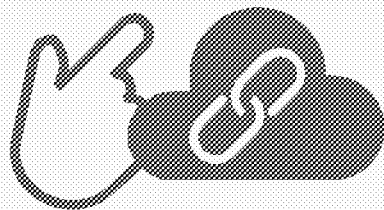


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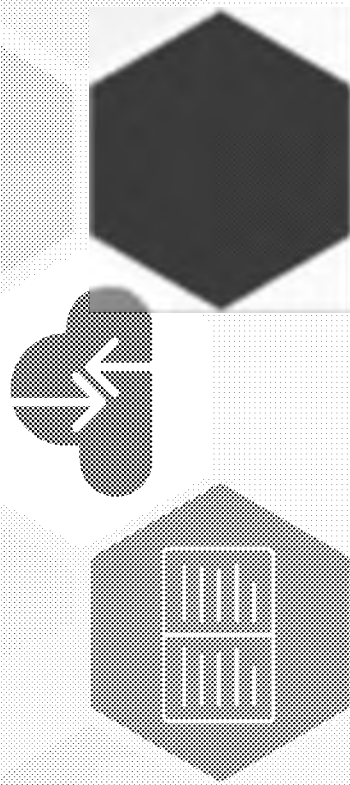


You can also click on the icon on the bottom left to go back to the table of contents.

Please note: This guide was prepared for informational purposes only and isn't intended to grant rights or impose obligations. The information provided is only intended to be a general summary. It isn't intended to take the place of the written law, including the regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

Hyperlinks

Hyperlinks to the [Quality Payment Program website](#) are included throughout the guide to direct the reader to more information and resources.



Overview

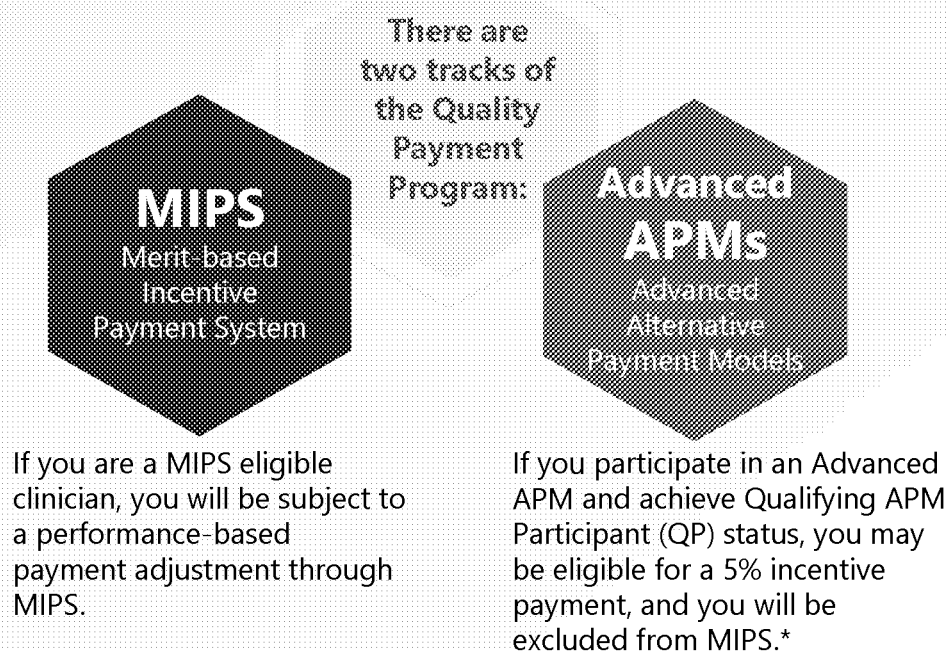
COVID-19 and 2022 Participation

The 2019 Coronavirus (COVID-19) public health emergency continues to impact clinicians across the United States and territories. However, we recognize that not all practices have been impacted by COVID-19 to the same extent. For the 2022 performance year, we'll continue to use our Extreme and Uncontrollable Circumstances policy to allow MIPS eligible clinicians, groups, virtual groups, and APM Entities to [submit an application](#) requesting reweighting of one or more MIPS performance categories to 0% due to the current COVID-19 public health emergency. The application will be available in spring of 2022 along with additional resources.

For more information about the impact of COVID-19 on Quality Payment Program (QPP) participation, see the [QPP COVID-19 Response webpage](#).

What is the Quality Payment Program?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula, which would have resulted in a significant cut to Medicare payment rates for clinicians. MACRA advances a forward-looking, coordinated framework for clinicians to successfully participate in the QPP, which rewards value in 1 of 2 ways:



***Note:** If you participate in an Advanced APM and don't achieve QP or Partial QP status, you will be subject to a performance-based payment adjustment through MIPS unless you are otherwise excluded.

What is the Merit-based Incentive Payment System?

The Merit-based Incentive Payment System (MIPS) is one way to participate in the QPP, a program authorized by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The program determines how we reimburse MIPS eligible clinicians for Part B covered professional services and rewards them for improving the quality of patient care and outcomes.

Under MIPS, we evaluate your performance across multiple categories that lead to improved quality and value in our healthcare system.

If you're eligible for MIPS in 2022:

- You generally have to submit data for the [quality, improvement activities, and Promoting Interoperability](#) performance categories. (We collect and calculate data for the [cost](#) performance category for you.)
- Your performance across the MIPS performance categories, each with a specific weight, will result in a MIPS final score of 0 to 100 points.
- Your MIPS final score will determine whether you receive a negative, neutral, or positive MIPS payment adjustment.
- Your MIPS payment adjustment is based on your performance during the 2022 performance year and applied to payments for covered professional services beginning on January 1, 2024.

To learn more about MIPS eligibility and participation options:

- Visit the [How MIPS Eligibility is Determined and Participation Options Overview](#) webpages on the [Quality Payment Program website](#).
- View the [2022 MIPS Eligibility and Participation Quick Start Guide \(PDF\)](#).
- Check your current MIPS participation status using the [QPP Participation Status Tool](#).

What is the Merit-based Incentive Payment System? (Continued)

Traditional MIPS, established in the first year of the QPP, is the original framework for collecting and reporting data to MIPS.

Under the traditional MIPS, participants select from 200 quality measures and over 100 improvement activities, in addition to reporting the complete Promoting Interoperability measure set. We collect and calculate data for the cost performance category for you.

In addition to traditional MIPS, 2 other MIPS reporting frameworks, designed to reduce reporting burden, will be available to MIPS eligible clinicians.

- The **APM Performance Pathway (APP)** is a streamlined reporting framework available beginning with the 2021 performance year for MIPS eligible clinicians who participate in a MIPS APM. The APP is designed to reduce reporting burden, create new scoring opportunities for participants in MIPS APMs, and encourage participation in APMs.
- **MIPS Value Pathways (MVPs)** are subsets of measures and activities, established through rulemaking, that can be used to meet MIPS reporting requirements beginning with the 2023 performance year. The MVP framework aims to align and connect measures and activities across the quality, cost, and improvement activities performance categories of MIPS for different specialties or conditions. In addition, MVPs incorporate a foundational layer that leverages Promoting Interoperability measures and a set of administrative claims-based quality measures that focus on population health/public health priorities. **There are currently 7 MVPs that will be available for reporting in the 2023 performance year:**

1. Advancing Rheumatology Patient Care
2. Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes
3. Advancing Care for Heart Disease
4. Optimizing Chronic Disease Management
5. Adopting Best Practices and Promoting Patient Safety within Emergency Medicine
6. Improving Care for Lower Extremity Joint Repair
7. Patient Safety and Support of Positive Experiences with Anesthesia

We encourage clinicians interested in reporting an applicable MVP to become familiar with the MVP's requirements in advance of the 2023 performance year. For more information on the finalized MVPs, please refer to the CY 2022 Physician Fee Schedule Final Rule. We'll also be adding more information to the [MIPS Value Pathways section of the QPP website](#).

What is the Merit-based Incentive Payment System? (Continued)

To learn more about the APP:

- Visit the [APM Performance Pathway \(APP\) webpage](#) on the Quality Payment Program website.
- View the following:
 - [2021 APM Performance Pathway \(APP\) for MIPS APM Participants Fact Sheet \(PDF\)](#);
 - [2021 APM Performance Pathway \(APP\) Infographic \(PDF\)](#);
 - [2021 APM Performance Pathway Quick Start Guide \(PDF\)](#).

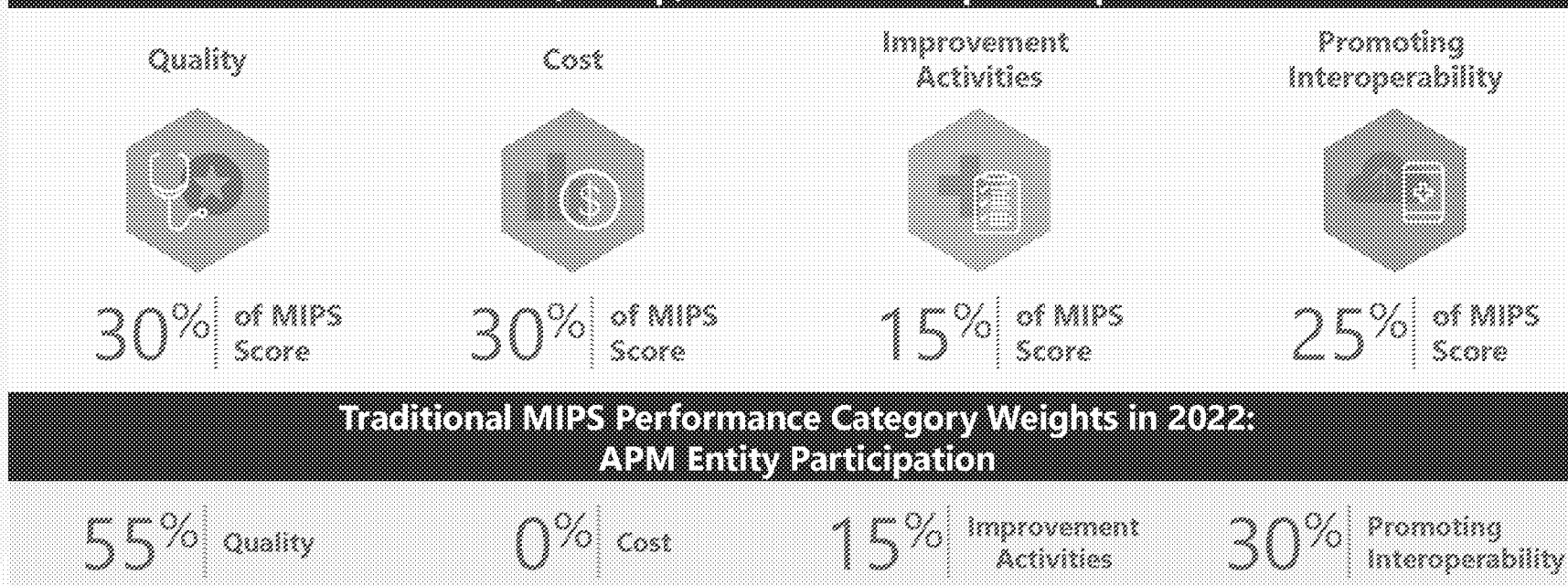
To learn more about MVPs:

- Visit the [MIPS Value Pathways \(MVPs\) webpage](#) on the Quality Payment Program website.

What is the Merit-based Incentive Payment System? (Continued)

This guide focuses on the **improvement activities** performance category under traditional MIPS for the 2022 performance year of the QPP.

Traditional MIPS Performance Category Weights in 2022: Individual, Group, and Virtual Group Participation



For information about the improvement activities performance category under the APP, please refer to the [2021 APM Performance Pathway \(APP\) for MIPS APM Participants Fact Sheet \(PDF\)](#) or the [2021 APM Performance Pathway Quick Start Guide \(PDF\)](#). For more information on participating in an APM, visit our [APMs Overview webpage](#) and check out our APM-related resources in the [QPP Resource Library](#).

NOTE: MIPS APM participants reporting under traditional MIPS will automatically receive 50% credit for the improvement activities performance category for the 2022 performance year.



Improvement Activities Basics

Improvement Activities Basics

What is the MIPS Improvement Activities Performance Category?

The improvement activities performance category assesses your participation in clinical activities that support the improvement of clinical practice, care delivery, and outcomes. With over 100 activities to choose from, you can select from the [2022 Improvement Activities Inventory \(ZIP\)](#) to find those that best fit your practice and support the needs of your patients.

The MIPS improvement activities are divided into the following eight subcategories:



Improvement Activities Basics

What is the MIPS Improvement Activities Performance Category? (Continued)

For 2022, the improvement activities performance category for traditional MIPS:

- ✦ Is worth 15% of your MIPS final score.
- ✦ Requires you to implement 2 to 4 improvement activities to receive the maximum score of 40 points in this performance category.
- ✦ Has a performance period of 90 continuous days for most improvement activities with a few exceptions.
- ✦ Requires you to simply attest to activities during the performance year (PY) 2022 submission window (1/3/2023 – 3/31/2023). While you do not have to submit any supporting data when you attest to completing an activity, you must keep documentation for 6 years subsequent to submission.

What's New with Improvement Activities in 2022?

New Improvement Activities

1. Create and Implement an Anti-Racism Plan (IA_AHE_8)
2. Implement Food Insecurity and Nutrition Risk Identification and Treatment Protocols (IA_AHE_9)
3. Implementation of a Trauma-Informed Care (TIC) Approach to Clinical Practice (IA_BMH_11)
4. Promoting Clinician Well-Being (IA_BMH_12)
5. Implementation of a Personal Protective Equipment (PPE) Plan (IA_ERP_4)
6. Implementation of a Laboratory Preparedness Plan (IA_ERP_5)
7. Application of CDC's Training for Healthcare Providers on Lyme Disease (IA_PSPA_33)

7 Added

Improvement Activities Basics

What is the MIPS Improvement Activities Performance Category? (Continued)

What's New with Improvement Activities in 2022? (Continued)

Modified Improvement Activities:

15
Modified

1. Enhance Engagement of Medicaid and Other Underserved Populations (IA_AHE_1)
2. MIPS Eligible Clinician Leadership in Clinical Trials or CBPR (IA_AHE_5)
3. Use of Certified EHR to Capture Patient Reported Outcomes (IA_BE_1)
4. Regularly Assess Patient Experience of Care and Follow Up on Findings (IA_BE_6)
5. Promote Self-Management in Usual Care (IA_BE_16)
6. Drug Cost Transparency (IA_BE_25)
7. Practice Improvements that Engage Community Resources to Support Patient Health Goals (IA_CC_14)
8. PSH Care Coordination (IA_CC_15)
9. Provide 24/7 Access to MIPS Eligible Clinicians or Groups Who Have Real-Time Access to Patient's Medical Record (IA_EPA_1)
10. Use of Telehealth Services that Expand Practice Access (IA_EPA_2)
11. Use of Toolsets or Other Resources to Close Health and Health Care Inequities Across Communities (IA_PM_6)
12. Regular Review Practices in Place on Targeted Patient Population Needs (IA_PM_11)
13. Consultation of the Prescription Drug Monitoring Program (IA_PSPA_6)
14. Measurement and Improvement at the Practice and Panel Level (IA_PSPA_18)
15. COVID-19 Clinical Data Reporting with or without Clinical Trial (IA_ERP_3)

Removed Improvement Activities:

6
Removed

1. Regularly Assess the Patient Experience of Care through Surveys, Advisory Councils and/or Other Mechanisms (IA_BE_13)
2. Participation in CAHPS or Other Supplemental Questionnaire (IA_PSPA_11)
3. Use of Tools to Assist Patient Self-Management (IA_BE_17)
4. Provide Peer-Led Support for Self-Management (IA_BE_18)
5. Implementation of Condition-Specific Chronic Disease Self-Management Support Programs (IA_BE_20)
6. Improved Practices that Disseminate Appropriate Self-Management Materials (IA_BE_21)

Improvement Activities Basics

What is the MIPS Improvement Activities Performance Category? (Continued)

What's New with Improvement Activities in 2022? (Continued)

Small Practices

We've modified the performance category weight redistribution policies for small practices to more heavily weight the improvement activities performance category when the Promoting Interoperability, or Promoting Interoperability and cost, performance categories are reweighted to 0%.

- **When the Promoting Interoperability performance category is reweighted:**
 - The quality performance category will be weighted at 40%.
 - The cost performance category will be weighted at 30%.
 - The improvement activities performance category will be weighted at 30%.
- **When both the cost and Promoting Interoperability performance categories are reweighted:**
 - The quality performance category will be weighted at 50%.
 - The improvement activities performance category will be weighted at 50%.

Under our existing policies, applicable to all MIPS eligible clinicians (not just those in small practices):

- **When both the quality and Promoting Interoperability performance categories are reweighted:**
 - The cost performance category will be weighted at 50%.
 - The improvement activities performance category will be weighted at 50%.

Improvement Activities Basics

How Do I Choose Improvement Activities?

You should select activities that are most meaningful to your practice and support the needs of your patients by improving patient engagement, care coordination, patient safety, health equity, and other areas in patient care. You might choose to focus on a particular subcategory or use the [Explore Measures & Activities Tool](#) to search for activities using keywords that align with your selected quality performance category measures.

For example, for one of your improvement activities, you might pair Glycemic Management Services (IA_PM_4) or Chronic Care and Preventative Care Management for Empaneled Patients (IA_PM_13) with Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) (Quality ID 001), Diabetes: Medical Attention for Nephropathy (Quality ID 119), and/or Controlling High Blood Pressure (Quality ID 236).

When selecting improvement activities, here are some questions you should consider:

Will you be reporting as a group, virtual group, or APM Entity?

If you plan to report as a group, virtual group, or APM Entity, **at least 50% of the eligible clinicians in the group, virtual group, or APM Entity must implement the same activity** during any continuous 90-day period (or as the period specified in the activity description) in the same performance year in order to attest to that activity. Individual clinicians within the group, virtual group, or APM Entity can implement the activity during any continuous 90-day period (or the period specified in the activity description). For example, if there are a total of 4 clinicians in your virtual group, 2 or more clinicians will each need to implement the same improvement activity for the performance period specified in the activity description at some point during the 2022 performance year in order for the group to successfully attest to the activity. Assuming the activity has a 90-day performance period, one clinician can implement the activity from March 1, 2022 to June 30, 2022 and the other can implement the same activity from October 3, 2022 to December 31, 2022.

Do you have a special status designation?

The number of activities you'll need to implement and attest to receive the maximum score for the improvement activities performance category depends on whether or not you have any special designations (e.g., small practice, non-patient facing) or are part of a patient-centered medical home or comparable specialty practice or MIPS APM. Most clinicians must implement and attest to 2 to 4 improvement activities to receive the maximum score of 40 points. However, clinicians with certain special status designation only need to submit 1 to 2 improvement activities. See [page 21](#) for more information.

Improvement Activities Basics

How Do I Choose Improvement Activities? (Continued)

- **Who will attest to improvement activities?** You'll also want to consider how you plan to attest to the completion of your improvement activities during the PY 2022 submission period. For example, will a third-party intermediary attest on your behalf? If you are working with a Qualified Registry or Qualified Clinical Data Registry (QCDR), you should check the [2022 Qualified Registries Qualified Posting](#) or [2022 QCDRs Qualified Posting](#) to see if your vendor supports this performance category and/or desired activities. See [page 28](#) for more detail on submission options.
- **Have you attested to the activity in previous years?** Most activities can be reported in consecutive performance years, but some activities limit how frequently an activity can be implemented. For example, the description for Administration of the AHRQ Survey of Patient Safety Culture (IA_PSPA_4) states that the activity can only be implemented once every 4 years. Information on whether or not an activity can be reported across multiple years can be found in the [2022 Improvement Activities Inventory \(ZIP\)](#).
- **What are the documentation requirements?** While you do not have to submit any supporting data when you attest to completing an improvement activity, **you must keep documentation of the efforts you or your MIPS group undertook to meet the improvement activity for 6 years subsequent to submission.** Documentation guidance for each activity can be found in the [2022 MIPS Data Validation Criteria \(ZIP\)](#). Additional information on documentation also can be found on [slide 27](#). We suggest reviewing the data validation criteria you select your improvement activities to ensure you document your work appropriately.

For a full list of improvement activities, including descriptions, for the 2022 performance year, review the [2022 Improvement Activities Inventory \(ZIP\)](#) or the [Explore Measures & Activities Tool](#).

- Most, but not all, improvement activities have a continuous 90-day performance period, but several improvement activities require completion of modules where there is a year-long or alternate performance period. For instance, IA_CC_10, Care transition documentation practice improvements, has a 30-day reporting period. An activity's performance period is 90 days unless otherwise stated in the activity description.

- Each improvement activity can be reported only once for the 2022 performance year.

Improvement Activities Basics

What if I Provide Care to Patients with COVID-19?

We're continuing the high-weighted COVID-19 Clinical Data Reporting with or without Clinical Trial (IA_ERP_3) improvement activity for the 2022 performance year to provide an opportunity for clinicians to receive credit in MIPS for the important work they are doing across the country.

There are two ways MIPS eligible clinicians or groups can receive credit for the COVID-19 improvement activity:

A clinician must participate in a COVID-19 clinical trial utilizing a drug or biological product to treat a COVID-19 patient and report their findings through a clinical data repository or clinical drug registry for the duration of their study

OR

A clinician must participate in the care of COVID-19 patients and simultaneously submit relevant clinical data to a clinical data registry for ongoing or future COVID-19 research

While clinicians can choose any combination of improvement activities to submit to receive full credit in this performance category, clinicians working on COVID-19 research could pair the COVID-19 activity with IA_ERP_2, Participation in a 60-day or greater effort to support domestic or international humanitarian needs (high-weighted) for their submission. Note: See [page 21](#) for additional information about activity weights and points and the [2022 Improvement Activities Inventory \(ZIP\)](#) for additional improvement activities that may be applicable to your practice.

We intend for the COVID-19 Clinical Data Reporting with or without Clinical Trial improvement activity to be applicable to MIPS eligible clinicians who are reporting their COVID-19 related patient data to a clinical data registry, such as a registry found on the [National Institute of Health \(NIH\) website](#); a clinical data repository, such as Oracle's [COVID-19 Therapeutic Learning System](#); and clinicians participating in clinical trials, such as the [COVID-19 clinical trials](#) being conducted by the NIH. Oracle has developed and donated a system to the U.S. government that allows clinicians and patients at no cost to record the effectiveness of promising COVID-19 drug therapies. You can refer to the [2022 MIPS Data Validation Criteria \(ZIP\)](#) for additional examples of clinical data registries, clinical data repositories, and clinical trials. You can also refer to the [CY 2022 Physician Fee Schedule \(PFS\) Final Rule](#) for additional requirements on this improvement activity.





Participation Requirements

Participation Requirements

How Many Improvement Activities Do I Need to Implement and Attest to?

Most clinicians must implement and attest to 2 to 4 improvement activities to receive the maximum score of 40 points in this performance category.

Each improvement activity is worth 10 to 40 points depending on its weight (medium or high) and applicable special status designations.

NOTE: If you're reporting measures for the quality performance category as an APM Entity, you will also attest to improvement activities at the APM Entity level.

- **Participating as an individual?** Check the [OPP Participation Status Tool](#) or sign in to [gpp.cms.gov](#) for any special statuses assigned at the "Clinician Level."
- **Participating as a group?** Check the [OPP Participation Status Tool](#) or sign in to [gpp.cms.gov](#) for any special statuses assigned at the "Practice Level."
- **Participating as a virtual group?** Sign in to [gpp.cms.gov](#) to check for any special statuses assigned to the virtual group.
- **Participating as an APM Entity?** Sign in to [gpp.cms.gov](#) to check if the small status was assigned to the APM Entity. Small status designation for APM Entities will be displayed in mid-2022.

For most MIPS eligible clinicians, groups, virtual groups, and APM Entities:



Each medium-weighted activity is worth **10 points**



Each high-weighted activity is worth **20 points**

For MIPS eligible clinicians, groups, virtual groups, and APM Entities with certain special status designations (small practice, non-patient facing, rural, or Health Professional Shortage Area (HPSA)):



Each medium-weighted activity is worth **20 points**

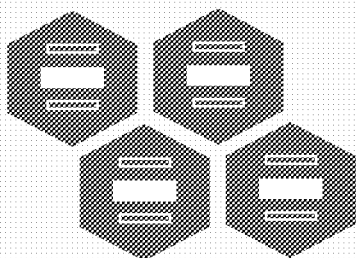


Each high-weighted activity is worth **40 points**

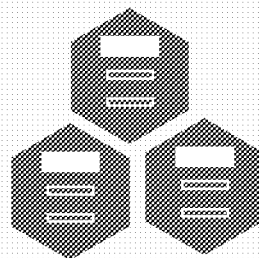
How Many Improvement Activities Do I Need to Implement and Attest to? (Continued)

To achieve the maximum 40 points for the MIPS improvement activities performance category, MIPS eligible clinicians, groups, virtual groups, and APM Entities may use one of the following combinations:

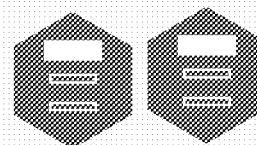
Activity combinations to reach the maximum 40 points for most MIPS eligible clinicians, groups, virtual groups, and APM Entities:



4 medium-weighted
activities = **40 points**



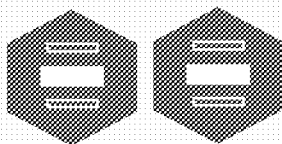
2 medium-weighted
activities + 1 high-weighted
activity = **40 points**



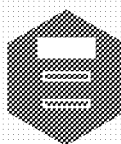
2 high-weighted activities =
40 points

TIP: If you do not attest to implementing any improvement activities, you will receive 0 points in this performance category.

Activity combinations to reach the maximum 40 points for those with certain special status designations (small practice, non-patient facing, rural, or Health Professional Shortage Area (HPSA)):



2 medium-weighted
activities = **40 points**



1 high-weighted activity =
40 points

For a full list of improvement activities for the 2022 performance year, including activity weights and descriptions, see the [2022 Improvement Activities Inventory \(ZIP\)](#) or the [Explore Measures & Activities Tool](#).

Participation Requirements

What If I Participate in a Patient-Centered Medical Home?

A MIPS eligible clinician who is in a practice that is certified or recognized as a patient-centered medical home or comparable specialty practice will receive 100% (full credit) for the improvement activities performance category. If reporting as a group, at least 50% of the practice sites within a group's TIN must be recognized as a patient-centered medical home or comparable specialty practice.

To be eligible for patient-centered medical home designation, the practice needs to meet one of the following for at least a continuous 90-day period during PY 2022 (to begin no later than October 3, 2022):

- Have received accreditation from an accreditation organization that is nationally recognized;
- Be participating in a Medicaid Medical Home or Medical Home Model;
- Be a comparable specialty practice that has received recognition through a specialty recognition program offered through a nationally recognized accreditation organization; or
- Have received accreditation from other certifying bodies that have certified a large number of medical organizations and meet national guidelines, as determined by the Secretary.

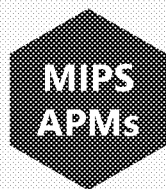
REMINDER: A MIPS eligible clinician or group must attest to their status as a patient-centered medical home or comparable specialty practice during the PY 2022 submission period in order to receive full credit for the improvement activities performance category. This credit isn't automatically awarded.

Participation Requirements

What If I Participate in an APM or MIPS APM?

If you're a MIPS eligible clinician identified as participating in an Alternative Payment Model (APM) or MIPS APM, you will automatically receive 20 points (out of 40 possible) for the MIPS improvement activities performance category under traditional MIPS. If you're a MIPS APM participant, you will receive full credit (40 points) if you're reporting the APP. See the [APP webpage](#) for more information.

For the 2022 performance year, these models include:



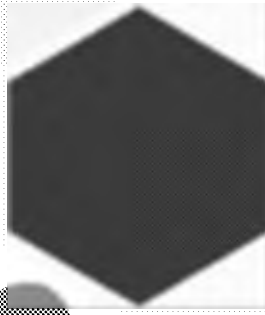
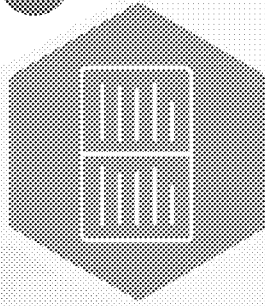
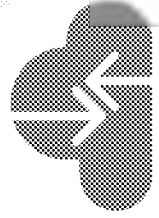
- Comprehensive Care for Joint Replacement (CJR) Model
- Comprehensive ESRD Care (CEC) Model
- Direct Contracting (DC) Professional PBP Model and Global PBP Model
- Independence at Home Demonstration (IAH)
- Kidney Care Choices Model: Comprehensive Kidney Care Contracting (CKCC) Graduated Option Level 1, and Level 2
- Kidney Care Choices Model: Comprehensive Kidney Care Contracting (CKCC) Professional Option
- Kidney Care Choices Model: Comprehensive Kidney Care Contracting (CKCC) Global Option
- Kidney Care Choices Model: Kidney Care First (KCF)
- Maryland Primary Care Program
- Maryland All-Payer Model: Care Redesign Program
- Medicare Shared Savings Program Accountable Care Organizations
- Oncology Care Model (OCM)
- Primary Care First (PCF)
- Value in Opioid Use Disorder Treatment (ViT) Demonstration Program
- Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)



- Accountable Health Communities (AHC)
- Frontier Community Health Integration Project Demonstration

You will need to submit data for one or more MIPS performance categories to receive the points awarded for APM or MIPS APM participation and select additional improvement activities to achieve the highest score (40 points).

NOTE: We will identify MIPS APM participants on the [QPP Participation Status Tool](#) as this information becomes available, beginning in summer 2022. We also will publish resources on improvement activity requirements for MIPS APMs to the [QPP Resource Library](#) later in 2022.



Reporting/Submission Requirements

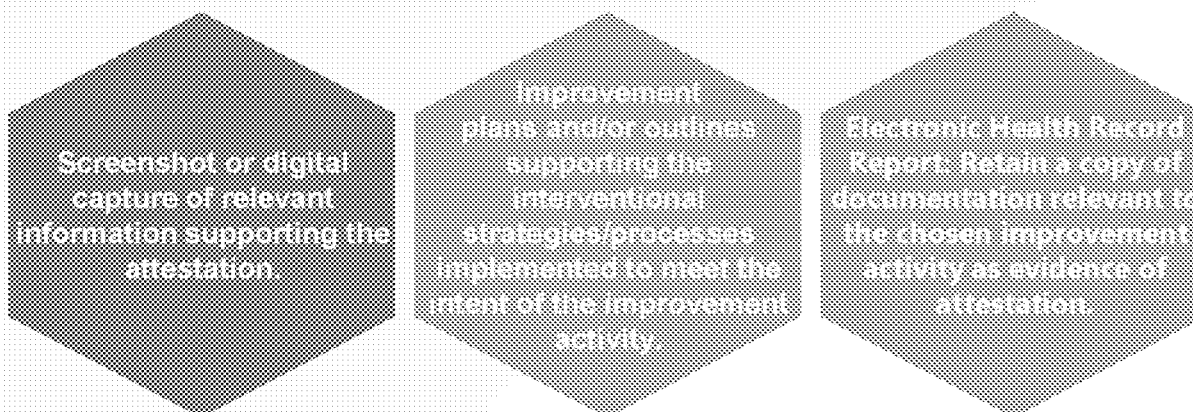
How and When Do I Report/Attest to Improvement Activities?

To report (or “submit”) an improvement activity, MIPS eligible clinicians, groups, virtual groups, and APM Entities simply attest to having completed it. No supporting data needs to accompany the attestation as part of the submission.

You will need to attest to the completion of your improvement activities or patient-centered medical home participation during the PY 2022 submission period (1/3/2023 – 3/31/2023).

While you do not have to submit any supporting documentation when you attest to completing an improvement activity, you must keep documentation of the efforts you or your MIPS group undertook to meet the improvement activity for 6 years subsequent to submission. Documentation guidance for each activity can be found in the [2022 MIPS Data Validation Criteria \(ZIP\)](#), which contains examples of ways to demonstrate completion of each improvement activity and clarifies the flexibilities clinicians have in implementing the activities.

Common examples of documentation may include, but are not limited to:

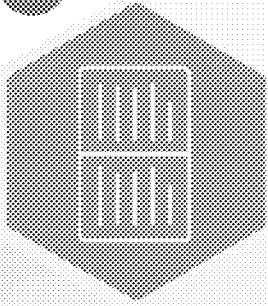
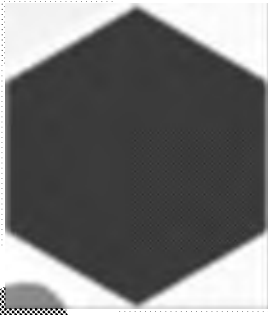


What are My Submission Options?

Your improvement activities performance category attestation data can be submitted using the following submission types:

Who	How
You (Clinician or Practice Representative)	Individual clinicians, groups, virtual groups, and APM Entities with a set of authenticated credentials can sign in and manually attest to their improvement activities data on qpp.cms.gov . For each improvement activity that is implemented for a continuous 90 days (unless otherwise stated in the activity description) during the performance year, you must attest to the improvement activity by submitting a "yes" response for each of these improvement activities.
You or a third party	Individual clinicians, groups, virtual groups, APM Entities, and third-party intermediaries can sign in and upload a QPP JSON file with your activity attestations on qpp.cms.gov .
Third party	Third-party intermediaries can perform a direct submission , transmitting data through a computer-to-computer interaction using our QPP submission Application Programming Interface (API).

TIP: To submit your attestations, you or your third-party representative will need QPP credentials and authorization. See the [QPP Access User Guide \(ZIP\)](#) for more information. Note that simply participating with a QCDR and having them submit data for the quality or Promoting Interoperability performance categories does not satisfy any requirements for the improvement activities performance category.



Scoring

How is the Performance Category Scored?

The improvement activities performance category is **15% of your MIPS final score** in 2022.

This is how the improvement activities performance category is scored:

The diagram illustrates the calculation of the Improvement Activities Performance Category Score. It features a large grey hexagon on the left containing the text "Improvement Activities Performance Category Score". To its right is an equals sign, followed by a rectangular box containing a fraction: "Total Number of Points Scored for Completed Activities" over "Total Maximum Number of Points (40)". To the right of this box is a multiplication symbol, followed by a smaller grey hexagon containing "100%".

$$\text{Improvement Activities Performance Category Score} = \frac{\text{Total Number of Points Scored for Completed Activities}}{\text{Total Maximum Number of Points (40)}} \times 100\%$$

Your improvement activities performance category score is then multiplied by the 15% improvement activities performance category weight. The overall improvement activities performance category score is added to the other performance category scores to determine your MIPS final score.

TIP: You can't earn more than 40 points in this performance category, regardless of the number of activities you submit. Please note that submission platforms may allow you to attest to more than 40 points-worth of activities. If you do attest to more than 40-points worth of activities, you are responsible for compiling and maintaining documentation for all activities to which you attest even though these additional activities won't increase your score.

Scoring Scenarios

Scenario 1:

You are a MIPS eligible clinician in a large practice (more than 15 clinicians) and complete 1 medium-weighted improvement activity for 10 of 40 points in the performance category.

$$\frac{10 \text{ points}}{40 \text{ points}} = \frac{1 \text{ medium-weighted activity}}{\text{Available points: Improvement Activity}}$$

$$= 25\%$$

of available points for Improvement Activities

$$25\% \times 15\% = 3.75$$

Improvement Activities Score Improvement Activities Weight Improvement Activities points contribution to final MIPS score

Scoring Scenarios (Continued)

Scenario 2: (Small Practice)

You are a MIPS eligible clinician in a small practice (15 or fewer clinicians) and complete 1 medium-weighted improvement activity for 20 of 40 points in the performance category. You don't submit Promoting Interoperability data, which means the Promoting Interoperability performance category is automatically weighted at 0% and the improvement activities performance category is weighted at 30%. The 30% weight assumes you can be scored on at least 1 cost measure.

<div style="display: flex; justify-content: space-between;"> <div> <p>20 points</p> <hr/> <p>40 points</p> </div> <div> <p>1 medium-weighted activity</p> <p>Available points: Improvement Activity</p> </div> </div>	=	<p>50%</p> <p>of available points for Improvement Activities</p>	<div style="display: flex; align-items: center; justify-content: center;"> <div style="text-align: center;"> <p>50%</p> </div> <div style="font-size: 2em; margin: 0 10px;">X</div> <div style="text-align: center;"> <p>30%</p> </div> </div> <div style="display: flex; align-items: center; justify-content: center; margin-top: 10px;"> <div style="text-align: center;"> <p>Improvement Activities Score</p> </div> <div style="font-size: 2em; margin: 0 10px;">=</div> <div style="text-align: center;"> <p>15</p> </div> </div> <div style="display: flex; justify-content: space-around; margin-top: 10px; font-size: 0.8em;"> <div>Improvement Activities Score</div> <div>Improvement Activities Weight</div> <div>Improvement Activities points contribution to final MIPS score</div> </div>
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Scenario 3: (Small Practice)

You are a MIPS eligible clinician in a small practice (15 or fewer clinicians) and complete 1 medium-weighted improvement activity for 20 of 40 points in the performance category. You don't submit Promoting Interoperability data, which means the Promoting Interoperability performance category is automatically weighted at 0%. You can't be scored on any cost measure, which means the cost performance category is automatically weighted at 0%. As a result, the improvement activities performance category is weighted at 50% of your final score, with the other 50% coming from the quality performance category.

<div style="display: flex; justify-content: space-between;"> <div> <p>20 points</p> <hr/> <p>40 points</p> </div> <div> <p>1 medium-weighted activity</p> <p>Available points: Improvement Activity</p> </div> </div>	=	<p>50%</p> <p>of available points for Improvement Activities</p>	<div style="display: flex; align-items: center; justify-content: center;"> <div style="text-align: center;"> <p>50%</p> </div> <div style="font-size: 2em; margin: 0 10px;">X</div> <div style="text-align: center;"> <p>50%</p> </div> </div> <div style="display: flex; align-items: center; justify-content: center; margin-top: 10px;"> <div style="text-align: center;"> <p>Improvement Activities Score</p> </div> <div style="font-size: 2em; margin: 0 10px;">=</div> <div style="text-align: center;"> <p>25</p> </div> </div> <div style="display: flex; justify-content: space-around; margin-top: 10px; font-size: 0.8em;"> <div>Improvement Activities Score</div> <div>Improvement Activities Weight</div> <div>Improvement Activities points contribution to final MIPS score</div> </div>
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Scoring Scenarios (Continued)

Scenario 4:

You are a MIPS eligible clinician in a small practice (15 or fewer clinicians) and complete 1 high-weighted improvement activity and 1 medium-weighted improvement activity for 60 points in the performance category. However, because 40 is the maximum points awarded, you will receive 40 points total.

$\frac{40 \text{ points} + \cancel{60 \text{ points}}}{40 \text{ points}}$ <p>1 high- and 1 medium-weighted activity</p> <p>Available points: Improvement Activity</p>	$=$	100% 150%	$=$	$100\% \times 15\% = 15.00$	<p>Improvement Activities Score</p> <p>Improvement Activities Weight</p> <p>Improvement Activities points contribution to final MIPS score</p>
		<p>of available points for Improvement Activities</p>			

Scenario 5:

You are a MIPS eligible clinician located in a rural area and participating in a MIPS APM. You complete 1 medium-weighted improvement activity for 40 points total—20 points for the medium-weighted activity and 20 automatic points for participating in a MIPS APM.

$\frac{20 \text{ points} + 20 \text{ points}}{40 \text{ points}}$ <p>1 medium-weighted activity</p> <p>automatic credit for MIPS APM participation</p> <p>Available points: Improvement Activity</p>	$=$	100%	$=$	$100\% \times 15\% = 15.00$	<p>Improvement Activities Score</p> <p>Improvement Activities Weight</p> <p>Improvement Activities points contribution to final MIPS score</p>
		<p>of available points for Improvement Activities</p>			



Annual Call for Improvement Activities

How are Improvement Activities Determined Each Performance Year?

Each year we hold an “Annual Call for Improvement Activities” where stakeholders—including clinicians, professional organizations, researchers, consumer groups, and others—can identify and submit new improvement activities or modifications to an improvement activity for consideration in future years of MIPS.

Improvement activity nominations submitted from February through June are considered for the following calendar year rulemaking cycle for possible implementation starting two years later. Submissions received after the July deadline each year are considered for future years. For example, activities submitted prior to the July deadline in 2022 would be considered for inclusion in the 2024 MIPS performance year, for which rules would be published in calendar year 2023. For more information, review the [2022 Call for Measures and Activities Toolkit \(ZIP\)](#).

As established in 2021, in addition to the “Annual Call for Improvement Activities” nomination period, stakeholders may submit nominations during a public health emergency. Additionally, CMS may nominate improvement activities and would consider Health and Human Services (HHS)-nominated improvement activities all year long in order to address HHS initiatives in an expedited manner. Any HHS-nominated improvement activities and those submitted during a public health emergency would be proposed through rulemaking. See the QPP policies in the [CY 2021 PFS Final Rule](#) for additional information.

NOTE: Proposing a new improvement activity is completely voluntary and not a requirement of participation.

How are Improvement Activities Determined Each Performance Year? (Continued)

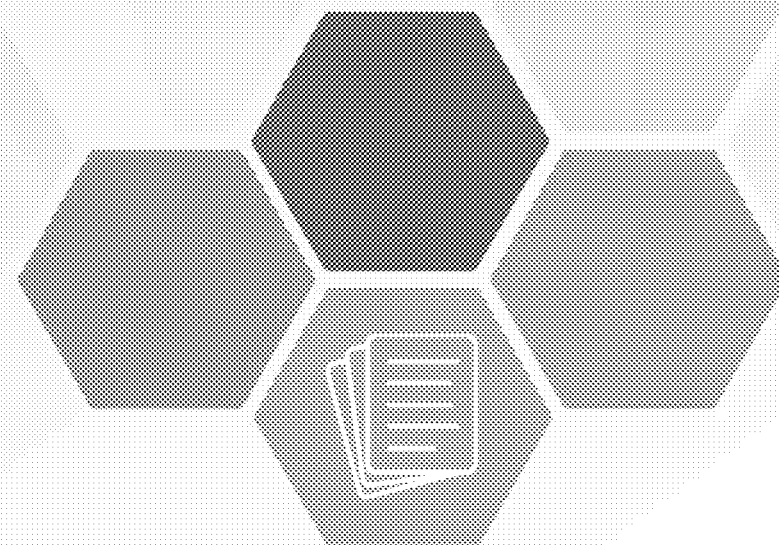
Beginning in 2022, new improvement activities must at minimum meet the following 8 criteria:

- New activities must not duplicate other improvement activities in the Inventory **(NEW)**
- New activities must drive improvements that go beyond standard clinical practices **(NEW)**
- Relevance to an existing improvement activities subcategory (or a proposed new subcategory).
- Importance of an activity toward achieving improved beneficiary health outcomes.
- Feasible to implement, recognizing importance in minimizing burden, including, to the extent possible, for small practices, practices in rural areas, or in areas designated as geographic Health Professional Shortage Areas by the Health Resources and Services Administration.
- Evidence supports that an activity has a high probability of contributing to improved beneficiary health outcomes.
- Can be linked to existing and related MIPS quality, Promoting Interoperability, and cost measures, as applicable and feasible.
- CMS can validate the activity.

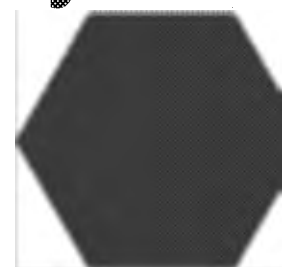
We may also consider the following 6 optional factors when reviewing nominated activities:

- Alignment with patient-centered medical homes.
- Support for the patient's family or personal caregiver.
- Responds to a public health emergency as determined by the Secretary.
- Addresses improvements in practice to reduce healthcare disparities.
- Focus on meaningful actions from the person and family's point of view.
- Representative of activities that multiple individual MIPS eligible clinicians or groups could perform (for example, primary care, specialty care).

NOTE: See the OPP policies in the CY 2022 PFS Final Rule for additional information.



Help, Resources, Glossary and Version History



Help, Resources, Glossary and Version History

Where Can You Go for Help?

Contact the Quality Payment Program Service Center at 1-866-288-8292, Monday through Friday, 8 a.m. - 8 p.m. ET or by e-mail at QPP@cms.hhs.gov. To receive assistance more quickly, please consider calling during non-peak hours—before 10 a.m. and after 2 p.m. ET.

- Customers who are hearing impaired can dial 711 to be connected to a TRS Communications Assistant.

Visit the [Quality Payment Program website](#) for other help and support information, to learn more about [MIPS](#), and to check out the resources available in the [QPP Resource Library](#).

Help, Resources, Glossary and Version History

Additional Resources

The [Quality Payment Program Resource Library](#) houses fact sheets, specialty guides, technical guides, user guides, helpful videos, and more. We will update this table as more resources become available.

- [2022 MIPS Quick Start Guide \(PDF\)](#)
- [2022 Eligibility and Participation Quick Start Guide: Traditional MIPS \(PDF\)](#)
- [2022 Improvement Activities Performance Category Quick Start Guide: Traditional MIPS \(PDF\)](#)
- [2022 Improvement Activities Inventory \(ZIP\)](#)
- [Improvement Activities Performance Category: Traditional MIPS Requirements Webpage](#)
- [2022 Call for Measures and Activities Toolkit \(ZIP\)](#)
- [2022 MIPS Data Validation Criteria \(ZIP\)](#)
- [QPP COVID-19 Response Fact Sheet \(PDF\)](#)
- [2022 Quality Payment Program Final Rule Resources \(ZIP\)](#)

Help, Resources, Glossary and Version History

Glossary



Help, Resources, Glossary and Version History

Version History

If we need to update this document, changes will be identified here.

Date	Description
03/14/2022	Original Posting.

Quality Payment PROGRAM

Merit-based Incentive Payment System (MIPS)

2022 MIPS Quick Start Guide



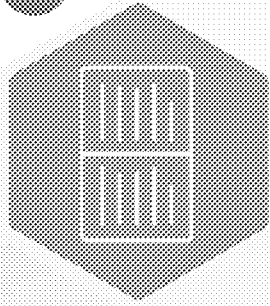
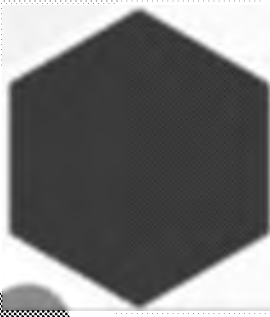
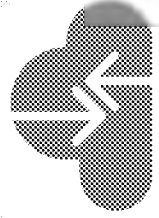
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Already know what MIPS is?

Skip ahead by clicking the links in the Table of Contents.

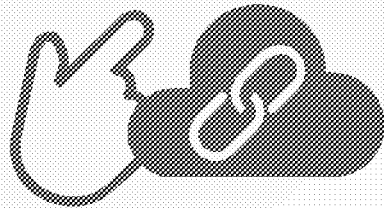
<u>How to Use This Guide</u>	<u>3</u>
<u>Overview</u>	<u>5</u>
• <u>What is the Quality Payment Program?</u>	<u>6</u>
• <u>What is the Merit-based Incentive Payment System?</u>	<u>7</u>
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Purpose: This resource provides a high-level overview of the Merit-based Incentive Payment System (MIPS) requirements to get you started with participating in the 2022 performance year.



How to Use This Guide

How to Use This Guide



Please note: This guide was prepared for informational purposes only and isn't intended to grant rights or impose obligations. The information provided is only intended to be a general summary. It isn't intended to take the place of the written law, including the regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

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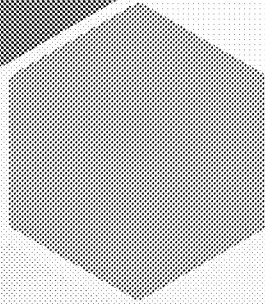
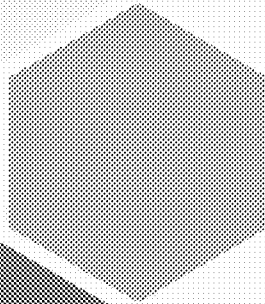
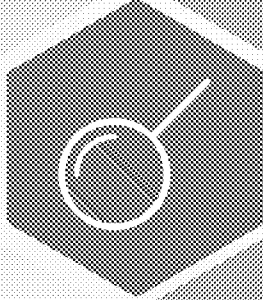
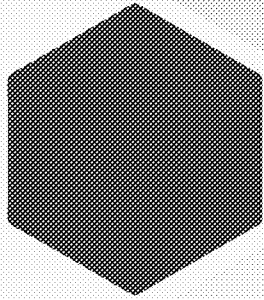
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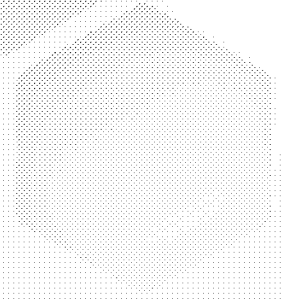
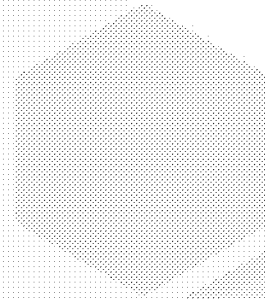
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Hyperlinks

Hyperlinks to the [Quality Payment Program website](#) are included throughout the guide to direct the reader to more information and resources.

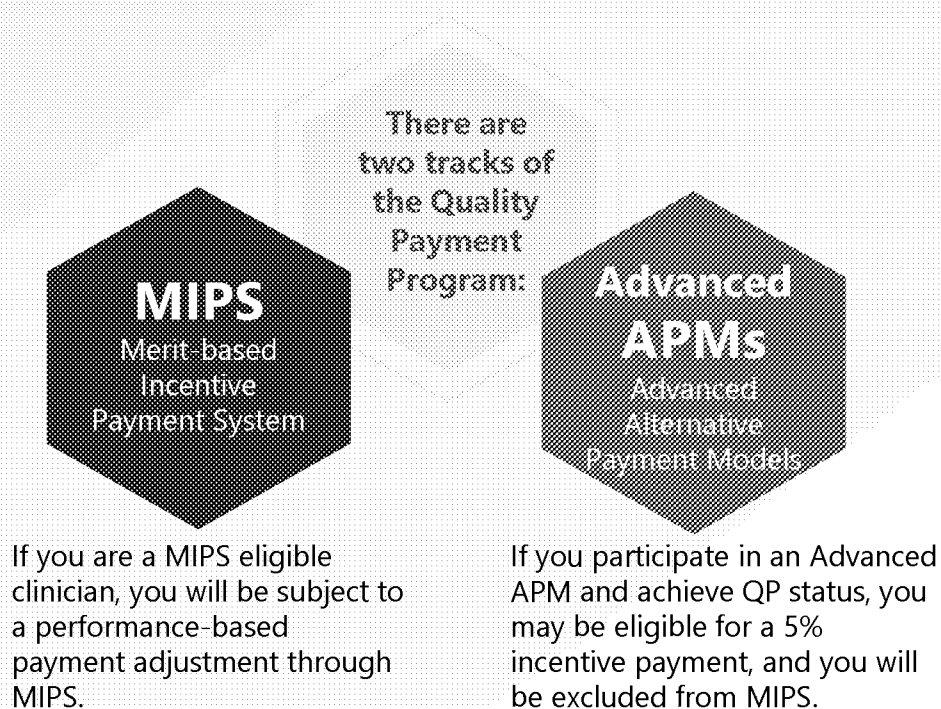


Overview



What is the Quality Payment Program?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula, which would have resulted in a significant cut to payment rates for clinicians participating in Medicare. MACRA advances a forward-looking, coordinated framework for clinicians to participate in the Quality Payment Program, which rewards value in 1 of 2 ways:



This guide will only cover the **MIPS participation in the Quality Payment Program**. For more information on participating in an Advanced APM, visit our [Advanced APM Overview webpage](#) and check out our APM related resources in the [Quality Payment Program Resource Library](#).

What is the Merit-based Incentive Payment System?

The Merit-based Incentive Payment System (MIPS) is one way to participate in the Quality Payment Program (QPP). The program describes how we reimburse MIPS eligible clinicians for Part B covered professional services and rewards them for improving the quality of patient care and outcomes.

Under MIPS, we evaluate your performance across multiple categories that lead to improved quality and value in our healthcare system.



What is the Merit-based Incentive Payment System? (Continued)

If you're eligible for MIPS in 2022:

- You generally have to submit data for the quality, improvement activities, and Promoting Interoperability performance categories. (We collect and calculate data for the cost performance category for you.)
- Your performance across the MIPS performance categories, each with a specific weight, will result in a MIPS final score of 0 to 100 points.
- Your MIPS final score will determine whether you receive a negative, neutral, or positive MIPS payment adjustment.
- Your MIPS payment adjustment is based on your performance during the 2022 performance year and applied to payments for covered professional services beginning on January 1, 2024.

What is the Merit-based Incentive Payment System? (Continued)

Traditional MIPS, established in the first year of the QPP, is the original framework for collecting and reporting data to MIPS.

Under the traditional MIPS, participants select from 200 quality measures and over 100 improvement activities, in addition to reporting the complete Promoting Interoperability measure set. We collect and calculate data for the cost performance category for you.

In addition to traditional MIPS, 2 other MIPS reporting frameworks, designed to reduce reporting burden, will be available to MIPS eligible clinicians.

- The **APM Performance Pathway (APP)**, is a streamlined reporting framework available beginning with the 2021 performance year for MIPS eligible clinicians who participate in a MIPS APM. The APP is designed to reduce reporting burden, create new scoring opportunities for participants in MIPS APMs, and encourage participation in APMs.
- **MIPS Value Pathways (MVPs)** are subsets of measures and activities, established through rulemaking, that can be used to meet MIPS reporting requirements beginning with the 2023 performance year. The MVP framework aims to align and connect measures and activities across the quality, cost, and improvement activities performance categories of MIPS for different specialties or conditions. In addition, MVPs incorporate a foundational layer that leverages Promoting Interoperability measures and a set of administrative claims-based quality measures that focus on population health/public health priorities. **There are 7 MVPs that will be available for reporting in the 2023 performance year:**

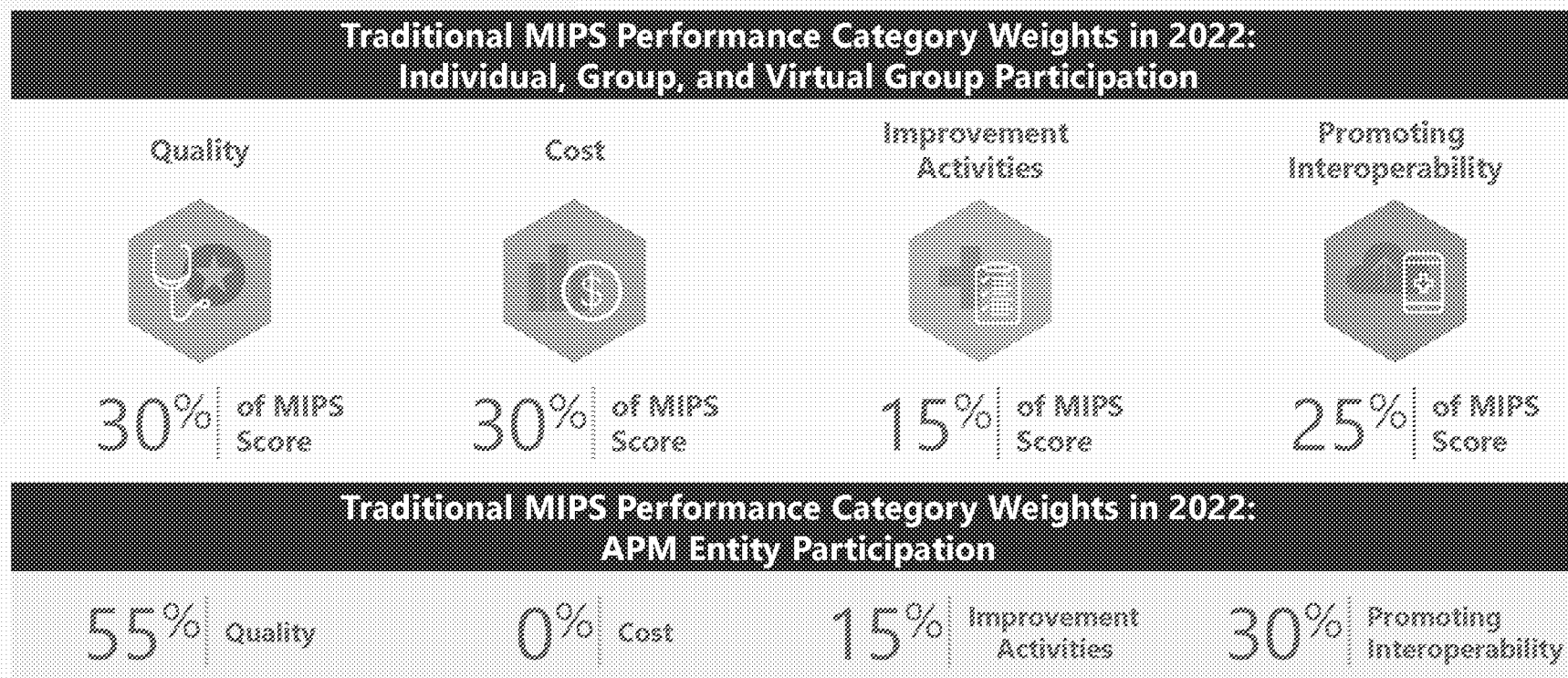
1. Advancing Rheumatology Patient Care
2. Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes
3. Advancing Care for Heart Disease
4. Optimizing Chronic Disease Management
5. Adopting Best Practices and Promoting Patient Safety within Emergency Medicine
6. Improving Care for Lower Extremity Joint Repair
7. Support of Positive Experiences with Anesthesia

We encourage clinicians interested in reporting an applicable MVP to become familiar with the MVP's requirements in advance of the 2023 performance year. For more information on the finalized MVPs, please refer to the CY 2022 Physician Fee Schedule Final Rule. We'll also be adding more information to [MIPS Value Pathways section of the QPP website](#).

MIPS Performance Category Scoring

The MIPS performance categories have different “weights,” and the scores from each of the categories are added together to give you a MIPS Final Score. Traditional MIPS performance category weights are dependent on the level for which you participate in MIPS.

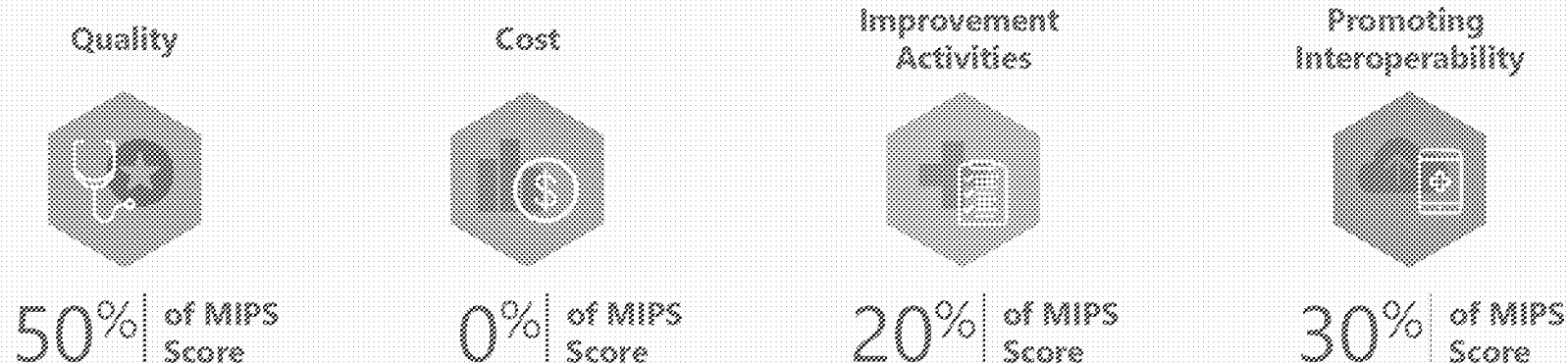
For example, MIPS eligible clinicians that participate in traditional MIPS as an APM Entity have different performance category weights than clinicians who participate in traditional MIPS as an individual, group, or virtual group.



MIPS Performance Category Scoring (Continued)

The MIPS performance categories have different “weights” and the scores from each of the categories are added together to give you a MIPS Final Score.

APM Performance Pathway (APP) MIPS Performance Category Weights in 2022: Individual, Group, and APM Entity Participation





Get Started with MIPS in 9 Steps

Get Started with MIPS in 9 Steps

9 Steps to Get Started

The 2022 MIPS performance year is January 1, 2022 to December 31, 2022. Following the performance year, you'll submit 2022 data for MIPS by March 31, 2023, which will result in a final score. You'll receive a positive, negative, or neutral payment adjustment in the 2024 payment year, which will be based on your 2022 MIPS final score.

If you're an eligible clinician, you should:

Step 1: Check your initial MIPS eligibility (NOW)

- Check your current eligibility for the 2022 performance year by entering your 10-digit National Provider Identifier (NPI) in the [Quality Payment Program Participation Status Lookup Tool](#).
 - **Note:** Your preliminary eligibility will be available by January 1, 2022 and your final eligibility will be available in December 2022.
- We determine your eligibility by evaluating your clinician type, the volume of care you provide to Medicare patients (low volume threshold), your Medicare enrollment date (you must have been enrolled before January 1, 2022) and your Qualifying APM Participant (QP) status.*

Step 2: Determine how you will participate (NOW)

- **Individual:** collect and submit data for an individual clinician.
- **Group:** collect and submit data for all clinicians in the group.
- **Virtual Group:** collect and submit data for all clinicians in the CMS-approved virtual group.
- **APM Entity:** collect and submit data for MIPS eligible clinicians identified as participating in the MIPS APM.

Step 3: Determine your reporting framework (NOW)

- **Traditional MIPS**
 - MIPS reporting option available to all MIPS eligible clinicians
 - Can be reported by individuals, groups, virtual groups and APM Entities.
 - You select measures and activities to evaluate your performance across quality, improvement activities and Promoting Interoperability performance categories. We collect cost data for you.
- **APM Performance Pathways (APP)**
 - MIPS reporting option available to MIPS eligible clinicians in a MIPS APM
 - Can be reported by individuals, groups, and APM Entities.
 - **Required** for all Medicare Shared Savings Program ACOs
 - Uses a pre-determined measure set to evaluate your performance across quality, improvement activities and Promoting Interoperability.

*Your Qualifying APM Participant (QP) Status will be updated throughout the performance year, with final information anticipated to be available in December 2022. If you're determined to be a QP, you aren't eligible for MIPS.



Alternative Reporting Options

Quality Payment
PROGRAM

Get Started with MIPS in 9 Steps (Continued)

9 Steps to Get Started (Continued)

If you're an eligible clinician, you should:

Step 4a:
Select and Perform
Your Measures and
Activities
(throughout 2022)

Traditional MIPS

- **Quality:** Most clinicians must select 6 measures, collecting data for each measure for the 12-month performance period (January 1-December 31, 2022).
 - o To learn more, review the 2022 Quality Quick Start Guide.
- **Improvement Activities:** Most clinicians must select between 2 and 4 activities, performing each activity for a continuous 90-day period in Calendar Year (CY) 2022 (or as indicated in the activity's description).
 - o To learn more, review the 2022 Improvement Activities Quick Start Guide.
- **Promoting Interoperability:** Most clinicians must collect data using CEHRT on the required measures for the same continuous 90 (+)-day performance period in CY2022.
 - o To learn more, review the 2022 Promoting Interoperability Quick Start Guide.
- **Cost:** Clinicians don't need to collect or submit any data for cost measures. We collect and evaluate this data for you.
 - o To learn more, review the 2022 Cost Quick Start Guide.

Step 4b:
Perform Your
Measures (APP)
(throughout 2022)

APM Performance Pathway (APP)

- **Quality:** Clinicians must collect data for a set of pre-determined quality measures for the 12-month performance period (January 1-December 31, 2022). To learn more, review the [Quality Measures: APP Requirements](#) webpage.
- **Improvement Activities:** Clinicians who are MIPS APM participants and report to MIPS through the APP will automatically receive full credit for the Improvement Activities performance category score. To learn more, review the [Improvement Activities: APP Requirements](#) webpage.
- **Promoting Interoperability:** Clinicians must collect data on the 6 required measures for the same continuous 90 (+)-day performance period in CY2022. To learn more, review the [Promoting Interoperability Measures: APP Requirements](#) webpage.



Alternative Reporting Options

Quality Payment
PROGRAM

Get Started with MIPS in 9 Steps (Continued)

9 Steps to Get Started (Continued)

The 2022 MIPS performance year is January 1, 2022 to December 31, 2022. Following the performance year, you'll submit 2022 data for MIPS by March 31, 2023 which will result in a final score. You'll receive a positive, negative, or neutral payment adjustment in the 2024 payment year, which will be based on your 2022 MIPS final score.

If you're an eligible clinician, you should:

Step 5: Verify Your Eligibility (late 2022)

- Check the [Quality Payment Program Participation Status Lookup Tool](#) in December 2022 to confirm that you remain eligible for MIPS and a payment adjustment.

Step 6: Submit Your Data (early 2023)

- Submit data yourself or with the help of a third party intermediary, such as a Qualified Registry or Qualified Clinical Data Registry (QCDR), between January 3 and March 31, 2023.
 - Visit the [Quality Payment Program Resource Library](#) to review the lists of CMS-approved Qualified Registries and QCDRs.

Step 7: Review Your Performance Feedback (mid-2023)

- Preliminary feedback is available as soon as data is submitted.
- Final performance feedback and payment adjustment information will be available in Summer 2023.

Step 8: Note the application of payment adjustments (throughout 2024)

- Review your claims to see payment adjustments for your 2022 performance applied to covered professional services billed in 2024.

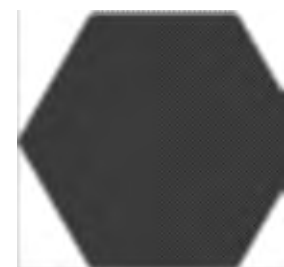
Step 9: Preview your data for public reporting (late 2023 or early 2024)

- Preview your 2022 MIPS performance data for public reporting in late 2023 or early 2024.





Help, Resources, and Version History



Help, Resources, and Version History

Where Can I Get Help?

Contact the Quality Payment Program at 1-866-288-8292, Monday through Friday, 8 a.m.-8 p.m. Eastern Time or by e-mail at: QPP@cms.hhs.gov.

- Customers who are hearing impaired can dial 711 to be connected to a TRS Communications Assistant.

Visit the Quality Payment Program [website](#) for other [help](#) and [support](#) information, to learn more about [MIPS](#), and to check out the resources available in the [Quality Payment Program Resource Library](#).

Help, Resources, and Version History

Additional Resources

The [Quality Payment Program Resource Library](#) houses fact sheets, specialty guides, technical guides, user guides, helpful videos, and more. We will update this table as more resources become available.

Resource	Description
2022 MIPS Eligibility and Participation Quick Start Guide	A high-level overview and actionable steps to understand your 2022 MIPS eligibility and participation requirements.
2022 MIPS Quality Performance Category Quick Start Guide	A high-level overview and practical information about quality measure selection, data collection and submission for the 2022 MIPS quality performance category.
2022 MIPS Promoting Interoperability Performance Category Quick Start Guide	A high-level overview and practical information about data collection and submission for the 2022 MIPS Promoting Interoperability performance category.
2022 Improvement Activities Quick Start Guide	A high-level overview and practical information about data collection and submission for the 2022 MIPS improvement activities performance category.
2022 MIPS Cost Performance Category Quick Start Guide	A high-level overview of cost measures, including calculation and attribution, for the 2022 MIPS cost performance category.
2022 APP Toolkit	An overview of the reporting and scoring pathway for MIPS eligible clinicians who participate in MIPS APMs: the APP.

Help, Resources, and Version History

Version History

If we need to update this document, changes will be identified here.

Date	Description
01/18/2022	Updated to reflect correct links on slide 18.
12/29/2021	Original Posting.

Quality Payment
PROGRAM

2022 Quality Payment Program Experience Report



MAY 2024

HHS_00000442

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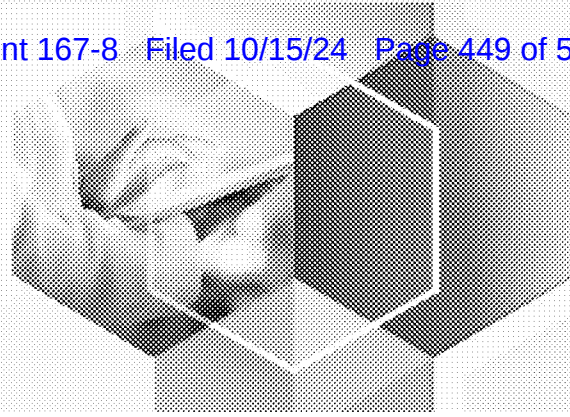
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List of Acronyms

ACO	Accountable Care Organization
API	Application Programming Interface
APM	Alternative Payment Model
APP	APM Performance Pathway
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CEHRT	Certified Electronic Health Record Technology
CMS	Centers for Medicare & Medicaid Services
COVID-19	Coronavirus Disease 2019
CQM	Clinical Quality Measure
eCQM	Electronic Clinical Quality Measure
EHR	Electronic Health Record
EUC	Extreme and Uncontrollable Circumstances
HWR	Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System (MIPS) Groups
MCC	Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions
MIPS	Merit-based Incentive Payment System
MSPB	Medicare Spending Per Beneficiary
NPI	National Provider Identifier
PHE	Public Health Emergency
QCDR	Qualified Clinical Data Registry
QPP	Quality Payment Program
QP	Qualifying APM Participant (in an Advanced APM)
TIN	Taxpayer Identification Number
TPCC	Total per Capita Cost

Quality Payment PROGRAM



A. Background

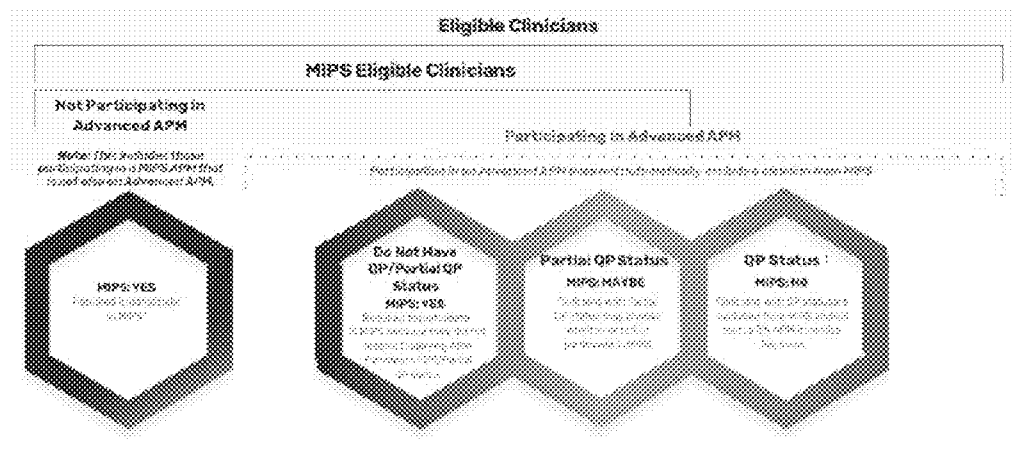
In 2017, the Centers for Medicare & Medicaid Services (CMS) launched the Quality Payment Program (QPP), which aims to reward improved patient outcomes and drive fundamental movement toward a value-based system of care. The program offers **2 payment tracks**: the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs).

The MIPS track evaluates clinicians on their overall performance in up to 4 performance categories: quality, cost, improvement activities, and Promoting Interoperability. MIPS eligible clinicians will receive a MIPS payment adjustment – positive, negative, or neutral – 2 years after the performance year. For example, payment adjustments made in 2024 are based on their performance in 2022.

The Advanced APM track provides an opportunity to reward clinicians for taking on greater risk and accountability for patient outcomes. Eligible clinicians who participated in an Advanced APM and achieved Qualifying APM Participant (QP) status, based on the level of their participation in 2022 through the Medicare or the All-Payer Combination Option, will be eligible to receive a 5% APM Incentive Payment in 2024. Eligible clinicians with QP status are also excluded from MIPS. If an eligible clinician participating in an Advanced APM doesn't achieve QP status for the year, they'll need to participate in MIPS, unless they're otherwise excluded.

Review the [Learning Resources for QP Status and APM Incentive Payment \(ZIP\)](#) and the [Advanced APM Participation](#) section of this report for more information.

Although QPP has 2 payment tracks, these tracks can overlap for clinicians participating in an Advanced APM:



1. Purpose of This Report

From the start of the QPP, CMS committed to being transparent with data and listening to feedback from interested parties. The primary goal of this report is to identify trends associated with the clinician experience during the 2022 performance year while identifying progress from previous years – 2019 and 2021 performance years. CMS used the 2019 performance year as a pre-Coronavirus Disease 2019 (COVID 19) public health emergency (PHE) comparison point.

In this report, data and insights are provided in the following 4 sections:

- **Section 1. MIPS Eligibility and Participation:** Reviews the participation and engagement of MIPS eligible clinicians, with detailed breakouts by special status, practice size, participation option and reporting option.
- **Section 2. MIPS Performance:** Reviews performance in the quality, cost, improvement activities, and Promoting Interoperability performance categories, with detailed breakouts in the quality performance category by frequency of reporting, scores, and specialty.
- **Section 3. 2022 MIPS Final Scores and Associated 2024 Payment Adjustments:** Reviews MIPS eligible clinicians' final scores and payment adjustments, with detailed breakouts by special status, practice size, participation option and reporting option.
- **Section 4. Advanced APM Participation:** Reviews the volume of eligible clinicians achieving QP status.

2. COVID-19 and 2022 Participation

In the 2022 performance year, we were able to start getting back on track with QPP policies and participation for the first time since the declaration of the COVID-19 (PHE) in March 2020.

Although we allowed clinicians to submit a MIPS Extreme and Uncontrollable Circumstances (EUC) Exception Application due to the COVID-19 PHE, we didn't apply this exception automatically to all MIPS eligible clinicians for the 2022 performance year. Visit the QPP website to learn more about our COVID-19 response in the 2022 performance year and the MIPS EUC Exception Application.

3. Additional Information

For more information on the data included in this report, please see the 2022 QPP Data Use Guide (PDF). Along with this report, CMS released the 2022 QPP Public Use File (PUF). The 2022 QPP PUF is a large dataset that includes clinician-level, non-aggregated data on clinician experience in the 2022 performance year. It will enable you to get some of the details behind the data in tables and figures presented in this report.

- **Aggregating the clinician-level data in the PUF won't result in the same data presented in this report.**
- **Clinicians in the PUF are identified by National Provider Identifier (NPI) and clinicians who see a low volume of Medicare patients (10 or fewer) will be excluded from the PUF due to privacy and public reporting standards.**

The 2022 QPP Participation and Performance Results At-A-Glance (PDF) was released at the same time as this report; the At-A-Glance resource provides a snapshot of aggregated data from this report.

B. Summary

The 2022 QPP Experience Report provides a glimpse into key program metrics, allowing interested parties to observe, identify trends in, and review changes to the experience of clinicians in the program. CMS has implemented changes with the data included and the way certain metrics are categorized, offering the opportunity to look at program data in a more targeted way.

In past years, the Experience Report has provided data that inspects clinician participation and performance overall as well as the results of those who **engaged**¹ with the program, or actively participated. Beginning with the 2022 Experience Report, CMS will also focus on **non-reporting**² clinicians (those who didn't report data at all). In addition, the data now distinguishes many of the metrics by practice size, allowing for distinction in the participation and performance results between solo practitioners and "small practices" – a defined term within QPP policy for practices with fewer than 16 clinicians, but that also includes solo practitioners. For example:

- Data shows that those MIPS eligible clinicians who engage¹ (actively participate) – regardless of practice size – are successful in the program. They have mean and median final scores above the 75-point performance threshold, resulting in positive payment adjustments.
- There is a notable difference in the performance of clinicians who engage¹ compared to those who don't.
 - Small practices, including solo practitioners, who engaged¹ achieved a mean final score of 84.8 points and a mean payment adjustment of 2.73%.
 - Small practices that didn't submit any data have a mean final score of only 38.34 and a mean payment adjustment of -4.6%.
- Data shows a consistent rate of non-reporting clinicians across performance years: About 6% of clinicians are individually eligible (required to report) but don't actively submit data.
- Solo practitioners have the highest rate of non-reporting clinicians (approximately 51%), although the number of solo practitioners who are required to participate has decreased in each performance year.

The 2022 report also includes **safety net provider**³ designations, along with breakouts by MIPS eligible clinician types and specialty. For example:

- Safety net providers³ have low rates of non-reporting clinicians and higher mean and median final scores than clinicians overall.
- The specialties with the highest proportion of clinicians receiving a negative payment adjustment are Anesthesiology, Orthopedic Surgery, Podiatry, and Optometry.
- The specialties with the highest proportion of clinicians receiving a positive payment adjustment are Obstetrics/Gynecology, Physical Therapy and General Surgery.

¹ **Engaged clinicians** are those who submitted at least one measure, attestation, or activity (or had this data submitted on their behalf), or who participated in a MIPS APM and received automatic credit in the improvement activities performance category because of their APM participation. Data could have been submitted at the individual, group, virtual group, or APM Entity level.

² **Non-reporting clinicians** were individually eligible for MIPS (and therefore required to participate) but didn't actively submit data. This includes clinicians who qualified for reweighting in one or more performance categories due to extreme and uncontrollable circumstances, exception applications, special status, or clinician type. These clinicians may still have been scored on administrative claims measures automatically calculated by CMS for the quality and cost performance categories.

³ **Safety net providers** are MIPS eligible clinicians who are in the top 20th percentile of all MIPS eligible clinicians in their percentage of patients who are enrolled in Medicare Part A and Part B and are also enrolled in full-benefit Medicaid.



Although the 2022 QPP Experience Report provides new ways to review program data, it continues to provide metrics that look at the big picture. For example:

- The **mean final score** for all MIPS eligible clinicians was **82.90 points** and the **median final score** was **85.29 points**.
 - Both the mean and the median exceeded the performance threshold of 75 points, the final score needed to avoid a negative payment adjustment.
- The **mean payment adjustment amount was 2.06%, the median was 0.92%, and the maximum was 8.26%**.
 - Mean and median scores both decreased between 2021 and 2022, whereas performance thresholds increased, resulting in higher payment adjustment amounts.
- Lower final scores overall (with some exceptions) can be attributed to the removal of quality measure bonus points, a change in the complex patient bonus methodology resulting in fewer clinicians being eligible for this bonus, the cost performance category being calculated for the first time since the 2019 performance year, and changes to performance category weights.

Finally, the report highlights clinician movement into Advanced APM participation, and their increasing levels of participation within their APM Entity as well. For example:

- Between 2021 and 2022, there was a **26% increase in Advanced APM participation** and a **41% increase in the number of clinicians who achieved QP status**.

C. Key Insights and Data Tables

1. MIPS Eligibility and Participation

Clinicians were included and required to participate in MIPS for the 2022 performance year if they met all of the following requirements: (1) Were a MIPS eligible clinician type; (2) enrolled as a Medicare provider before January 1, 2022; (3) exceeded the low-volume threshold, and (4) weren't otherwise excluded (for example, by achieving QP status).

We evaluate a clinician's eligibility for MIPS based on their National Provider Identifier (NPI) and associated Taxpayer Identification Number (TIN).

- When a clinician reassigns their billing rights to a TIN, their NPI becomes associated with the TIN.
 - This association is referred to as the TIN/NPI combination.
- When a clinician reassigns their billing rights to multiple TINs, the clinician establishes multiple TIN/NPI combinations.
- We evaluate clinicians for MIPS eligibility under each unique TIN/NPI combination.
- **MIPS policy defines a MIPS eligible clinician by a unique TIN/NPI combination, which is reflected in this report.**
 - An individual clinician who has multiple TIN/NPI combinations are counted multiple times in this report.

Clinicians who are individually eligible for MIPS are required to participate.

MIPS eligible clinicians are both physicians and non-physician clinicians who are eligible to participate in MIPS. Through rulemaking, CMS defines the MIPS eligible clinician types for a specific performance year. MIPS eligible clinician types in the 2022 performance year are listed [here](#).

In 2022, MIPS eligible clinicians could participate in MIPS as an [individual](#), a [group](#), a [virtual group](#), or an [APM Entity](#).

For detailed information about MIPS eligibility and participation in the 2022 performance year, please refer to the [Appendix](#).

Key Insights

1.1 Overall MIPS Participation

- There was a ~11% drop in the number of MIPS eligible clinicians between 2021 and 2022. (Tables 1 and 2) This decrease is likely due to an increase in clinicians achieving QP status ([Table 36](#)).
- The percentage of non-reporting clinicians remained the same between 2021 and 2022. (Table 1)
- For more information about the decrease in MIPS eligible clinicians between 2019 and 2021, please review the [2021 QPP Experience Report \(PDF, 5MB\)](#).

Table 1. Overall MIPS Participation

	2019	2021	2022
Number of MIPS Eligible Clinicians (All)	957,462	698,883	624,209
Number of MIPS Eligible Clinicians (Non-Reporting ⁴)	24,726	41,646	37,038
Percent of MIPS Eligible Clinicians (Non-Reporting)	2.58%	5.96%	5.93%

Table 2. Changes in MIPS Participation

	Change from 2019 to 2021 (Number)	Change from 2019 to 2021 (Percentage)	Change from 2021 to 2022 (Number)	Change from 2021 to 2022 (Percentage)
MIPS Eligible Clinicians (All)	-258,579	-27.01%	-74,674	-10.68%
MIPS Eligible Clinicians (Non-Reporting ⁴)	16,920	68.43%	-4,608	-11.06%

⁴ **Non-reporting MIPS eligible clinicians** who were individually eligible for MIPS (and therefore required to participate) but **didn't actively submit data**. This includes clinicians who qualified for reweighting in one or more performance categories due to extreme and uncontrollable circumstances, exception applications, special status, or clinician type. These clinicians may still have been scored on administrative claims measures automatically calculated by CMS for the quality and cost performance categories.

1.2 MIPS Participation by Practice Size and Special Status/Designation

- Solo practitioners have the highest rate of non-reporting clinicians (almost 51%) in 2022. Small practices with 2 – 15 clinicians have the highest decrease in participation from 2021 to 2022, with a ~20% non-reporting rate in 2022. (Table 3a)
- The rate of non-reporting has remained low for rural clinicians as well as those designated as safety net providers⁵. (Table 4a)

Table 3a. MIPS Participation by Practice Size

Practice Size ⁶	2019			2021			2022		
	Number of MIPS Eligible Clinicians (All)	Number of MIPS Eligible Clinicians (Non-Reporting ⁷)	Rate of Non-Reporting Clinicians	Number of MIPS Eligible Clinicians (All)	Number of MIPS Eligible Clinicians (Non-Reporting ⁷)	Rate of Non-Reporting Clinicians	Number of MIPS Eligible Clinicians (All)	Number of MIPS Eligible Clinicians (Non-Reporting ⁷)	Rate of Non-Reporting Clinicians
1 Clinician (Solo Practitioner)	32,637	9,538	29.22%	20,305	10,718	52.79%	17,937	9,126	50.88%
2 – 15 Clinicians	129,887	8,906	6.86%	89,364	15,265	17.08%	66,584	13,112	19.69%
16 – 99 Clinicians	259,019	4,725	1.82%	145,299	10,131	6.97%	125,174	9,678	7.73%
100+ Clinicians	535,919	1,557	0.29%	443,915	5,532	1.25%	414,514	5,122	1.24%

⁵ **Safety net providers** are MIPS eligible clinicians who are in the top 20th percentile of all MIPS eligible clinicians in their percentage of patients who are enrolled in Medicare Part A and Part B and are also enrolled in full-benefit Medicaid.

⁶ Practice size in Tables 3a and 3b is determined by the number of clinicians billing under the practice's TIN in the second 12-month segment of the MIPS determination period (October 1, 2021 – September 30, 2022, for 2022).

⁷ **Non-reporting clinicians** were individually eligible for MIPS (and therefore required to participate) but **didn't actively submit data**. This includes clinicians who qualified for reweighting in one or more performance categories due to extreme and uncontrollable circumstances, exception applications, special status, or clinician type. These clinicians may still have been scored on administrative claims measures automatically calculated by CMS for the quality and cost performance categories.

Table 3b. Changes in MIPS Participation by Practice Size

Practice Size ³	Change from 2019 to 2021 (Count)	Change from 2019 to 2021 (Percentage)	Change from 2021 to 2022 (Count)	Change from 2021 to 2022 (Percentage)
1 Clinician (Solo Practitioner)	-12,332	-37.79%	-2,368	-11.66%
2 – 15 Clinicians	-40,523	-31.20%	-22,780	-25.49%
16 – 99 Clinicians	-113,720	-43.90%	-20,125	-13.85%
100+ Clinicians	-92,004	-17.17%	-29,401	-6.62%

Table 4a. MIPS Participation by Special Status Designation

Special Status / Designation	2019			2021			2022		
	Number of MIPS Eligible Clinicians (All)	Number of MIPS Eligible Clinicians (Non-Reporting ⁸)	Rate of Non-Reporting Clinicians	Number of MIPS Eligible Clinicians (All)	Number of MIPS Eligible Clinicians (Non-Reporting)	Rate of Non-Reporting Clinicians	Number of MIPS Eligible Clinicians (All)	Number of MIPS Eligible Clinicians (Non-Reporting)	Rate of Non-Reporting Clinicians
Small Practice ⁹	125,705	18,643	14.83%	108,377	26,355	24.32%	84,713	22,599	26.68%
Rural	120,156	3,139	2.61%	89,107	5,242	5.88%	80,950	4,441	5.49%
Safety Net Provider	201,608	8,145	4.04%	143,120	11,443	8.00%	125,273	7,844	6.26%

⁸ **Non-reporting clinicians** were individually eligible for MIPS (and therefore required to participate) but **didn't actively submit data**. This includes clinicians who qualified for reweighting in one or more performance categories due to extreme and uncontrollable circumstances, exception applications, special status, or clinician type. These clinicians may still have been scored on administrative claims measures automatically calculated by CMS for the quality and cost performance categories.

⁹ The small practice special status in Tables 4a and 4b identifies clinicians in a practice with 15 or fewer clinicians who bill under the practice's TIN in either segment of the MIPS determination period. This means that a practice could have had 16 or more clinicians in 1 segment if there were 15 or fewer in the other segment.

Table 4b. Changes in MIPS Participation by Special Status/Designation

Special Status/Designation	Change from 2019 to 2021 (Count)	Change from 2019 to 2021 (Percentage)	Change from 2021 to 2022 (Count)	Change from 2021 to 2022 (Percentage)
Small Practice	-17,328	-13.78%	-23,664	-21.83%
Rural	-31,049	-25.84%	-8,157	-9.15%
Safety Net Provider	-58,488	-29.01%	-17,847	-12.47%

1.3 MIPS Participation by Clinician Type

- The most common clinician type in every year is Doctor of Medicine, followed by Nurse Practitioners. (Table 5)
- There's a consistent non-reporting rate (~8%) for Doctors of Medicine between 2021 and 2022, but a noticeable increase from 2019 (~3.5%). (Table 6)

Table 5. MIPS Participation and Non-Reporting by MIPS Eligible Clinician Type

	2019			2021			2022		
	Number of MIPS Eligible Clinicians (All)	Number of MIPS Eligible Clinicians (Non-Reporting ¹⁰)	Rate of Non-Reporting Clinicians	Number of MIPS Eligible Clinicians (All)	Number of Non-Reporting ¹⁰ MIPS Eligible Clinicians	Rate of Non-Reporting Clinicians	Number of MIPS Eligible Clinicians (All)	Number of Non-Reporting ¹⁰ MIPS Eligible Clinicians	Rate of Non-Reporting Clinicians
Overall	957,462	24,726	2.58%	698,883	41,646	5.96%	624,209	37,038	5.93%
Anesthesiologist Assistant¹¹	2,513	0	0.00%	1,627	0	0.00%	1,729	0	0.00%
Certified Nurse-Midwife¹²	N/A	N/A	N/A	N/A	N/A	N/A	2,004	4	0.20%
Certified Registered Nurse Anesthetist	46,947	163	0.35%	27,017	281	1.04%	26,805	193	0.72%

¹⁰ **Non-reporting clinicians** were individually eligible for MIPS (and therefore required to participate) but **didn't actively submit data**. This includes clinicians who qualified for reweighting in one or more performance categories due to extreme and uncontrollable circumstances, exception applications, special status, or clinician type. These clinicians may still have been scored on administrative claims measures automatically calculated by CMS for the quality and cost performance categories.

¹¹ Included in the definition of a Certified Registered Nurse Anesthetist (a MIPS eligible clinician type) in section 1861(bb)(2) of the Social Security Act.

¹² Certified Nurse Midwives and Clinical Social Workers became a MIPS eligible clinician type in the 2022 performance year.

	2019			2021			2022		
	Number of MIPS Eligible Clinicians (All)	Number of MIPS Eligible Clinicians (Non-Reporting ¹³)	Rate of Non-Reporting Clinicians	Number of MIPS Eligible Clinicians (All)	Number of Non-Reporting ¹³ MIPS Eligible Clinicians	Rate of Non-Reporting Clinicians	Number of MIPS Eligible Clinicians (All)	Number of Non-Reporting ¹³ MIPS Eligible Clinicians	Rate of Non-Reporting Clinicians
Clinical Nurse Specialist	1,161	17	1.46%	853	31	3.63%	680	13	1.91%
Clinical Psychologist	6,388	123	1.93%	4,699	164	3.49%	4,054	144	3.55%
Clinical Social Worker ¹²	N/A	N/A	N/A	N/A	N/A	N/A	4,335	37	0.85%
Doctor of Chiropractic (Chiropractor)	1,277	90	7.05%	946	81	8.56%	370	83	22.43%
Doctor of Dental Medicine/Doctor of Dental Surgery (Dentist)	812	17	2.09%	622	24	3.86%	539	14	2.60%
Doctor of Medicine	613,901	20,988	3.42%	462,518	37,048	8.01%	403,943	32,323	8.00%
Doctor of Optometry	10,812	386	3.57%	9,461	645	6.82%	7,456	589	7.90%
Doctor of Osteopathy	452	14	3.10%	325	14	4.31%	267	16	5.99%
Doctor of Podiatric Medicine ¹³	472	24	5.08%	0	0	0.00%	0	0	0.00%
Nurse Practitioner	111,688	1,387	1.24%	95,516	1,994	2.09%	87,816	1,937	2.21%
Occupational Therapist	2,668	41	1.54%	3,224	15	0.47%	2,405	39	1.62%
Physical Therapist	23,572	567	2.41%	23,509	377	1.60%	19,942	523	2.62%
Physician Assistant	80,219	683	0.85%	63,100	937	1.48%	57,536	1,111	1.93%

¹³ Please note that podiatrists could be captured in Medicare coding under Doctor of Podiatric Medicine or Doctor of Medicine in 2019. Beginning in 2021, podiatrists were captured exclusively under Doctor of Medicine.

	2019			2021			2022		
	Number of MIPS Eligible Clinicians (All)	Number of MIPS Eligible Clinicians (Non-Reporting ¹⁴)	Rate of Non-Reporting Clinicians	Number of MIPS Eligible Clinicians (All)	Number of Non-Reporting ¹⁴ MIPS Eligible Clinicians	Rate of Non-Reporting Clinicians	Number of MIPS Eligible Clinicians (All)	Number of Non-Reporting ¹⁴ MIPS Eligible Clinicians	Rate of Non-Reporting Clinicians
Qualified Audiologist	3,287	13	0.40%	2,635	18	0.68%	2,309	8	0.35%
Qualified Speech-Language Pathologist	607	0	0.00%	800	1	0.13%	583	0	0.00%
Registered Dietician/ Nutrition Professional	2,265	9	0.40%	2,007	16	0.80%	1,436	4	0.28%

Table 6. Changes in MIPS Participation by Clinician Type

	Change from 2019 to 2021 (Count)	Change from 2019 to 2021 (Percentage)	Change from 2021 to 2022 (Count)	Change from 2021 to 2022 (Percentage)
Anesthesiologist Assistant ¹⁴	-886	-35.26%	102	6.27%
Certified Nurse-Midwife	N/A ¹⁵	N/A	N/A	N/A
Certified Registered Nurse Anesthetist	-19,930	-42.45%	-212	-0.78%
Clinical Nurse Specialist	-308	-26.53%	-173	-20.28%
Clinical Psychologist	-1,689	-26.44%	-645	-13.73%
Clinical Social Worker	N/A	N/A	N/A	N/A
Doctor of Chiropractic (Chiropractor)	-331	-25.92%	-576	-60.89%
Doctor of Dental Medicine/Doctor of Dental Surgery (Dentist)	-190	-23.40%	-83	-13.34%

¹⁴ Included in the definition of a Certified Registered Nurse Anesthetist in section 1861(bb)(2) of the Social Security Act.

¹⁵ "N/A" is displayed when the clinician type count in either year was zero or "N/A".

	Change from 2019 to 2021 (Count)	Change from 2019 to 2021 (Percentage)	Change from 2021 to 2022 (Count)	Change from 2021 to 2022 (Percentage)
Doctor of Medicine	-151,383	-24.66%	-58,575	-12.66%
Doctor of Optometry	-1,351	-12.50%	-2,005	-21.19%
Doctor of Osteopathy	-127	-28.10%	-58	-17.85%
Doctor of Podiatric Medicine ¹⁶	- 472	N/A	N/A	N/A
Nurse Practitioner	-16,172	-14.48%	-7,700	-8.06%
Occupational Therapist	556	20.84%	-819	-25.40%
Physical Therapist	-63	-0.27%	-3,567	-15.17%
Physician Assistant	-17,119	-21.34%	-5,564	-8.82%
Qualified Audiologist	-652	-19.84%	-326	-12.37%
Qualified Speech-Language Pathologist	193	31.80%	-217	-27.13%
Registered Dietician/ Nutrition Professional	-258	-11.39%	-571	-28.45%

1.4 MIPS Participation by Participation Option

- MIPS participation options remained stable between 2021 and 2022, with approximately two-thirds of clinicians participating as a group. (Table 7)
- Individual participation has remained stable since 2019. (Table 7)
- For more information about the sizable shifts in group and APM Entity participation between 2019 and 2021, please review the [2021 QPP Experience Report](#).

¹⁶ Please note that Podiatrists could be captured in Medicare coding under Doctor of Podiatric Medicine or Doctor of Medicine in 2019. Beginning in 2021, Podiatrists were captured exclusively under Doctor of Medicine.

Table 7. MIPS Participation by Participation Option

Participation Option ¹⁷	2019		2021		2022	
	Number of MIPS Eligible Clinicians	Percent of All MIPS Eligible Clinicians	Number of MIPS Eligible Clinicians	Percent of All MIPS Eligible Clinicians	Number of MIPS Eligible Clinicians	Percent of All MIPS Eligible Clinicians
Overall	957,462	100.00%	698,883	100.00%	624,209	100.00%
Participate as Individual	60,681	6.34%	55,355	7.92%	46,242	7.41%
Participate as Group	477,713	49.89%	473,631	67.77%	427,425	68.47%
Participate as Virtual Group	75	0.01%	110	0.02%	94	0.02%
Participate as APM Entity	418,993	43.76%	169,787	24.29%	150,448	24.10%

Table 8. Changes in MIPS Participation Options

	2019		2021	
	Change from 2019 to 2021 (Count)	Change from 2019 to 2021 (Percentage)	Change from 2021 to 2022 (Count)	Change from 2021 to 2022 (Percentage)
Participate as Individual	-5,326	-8.78%	-9,113	-16.46%
Participate as Group	-4,082	-0.85%	-46,206	-9.76%
Participate as Virtual Group	35	46.67%	-16	-14.55%
Participate as APM Entity	-249,206	-59.48%	-19,339	-11.39%

¹⁷ This data reflects the participation option that resulted in the MIPS eligible clinician's final score. For example, if a clinician (under a single TIN/NPI combination) participated both as an individual and as part of a group, CMS would assign the higher final score – either from individual or group participation. If the individual score was higher, the clinician would be represented in the “individual” data; if the group score was higher, the clinician would be represented in the “group” data.

1.5 MIPS Participation by Reporting Option

- The number of MIPS eligible clinicians who received a final score from APM Performance Pathway (APP) reporting generally aligns with the number of clinicians who participated as an APM Entity (Table 7), though the APP can also be reported by individuals and groups.

Table 9. MIPS Participation by Reporting Option

MIPS Reporting Option	2021		2022	
	Number of MIPS Eligible Clinicians	Percent of All MIPS Eligible Clinicians	Number of MIPS Eligible Clinicians	Percent of All MIPS Eligible Clinicians
Traditional MIPS	529,754	75.80%	473,663	75.88%
APM Performance Pathway (APP) ¹⁸	169,129	24.20%	150,546	24.12%

Table 10. Changes in MIPS Participation by Reporting Option

MIPS Reporting Option	Change from 2021 to 2022 (Count)	Change from 2021 to 2022 (Percentage)
Traditional MIPS	-56,091	-10.59%
APM Performance Pathway (APP)	-18,583	-10.99%

¹⁸ The 2021 performance year was the first year that clinicians in a MIPS APM could report the APM Performance Pathway (APP). Prior to 2021, clinicians participating in a MIPS APM were scored according to the APM Scoring Standard.

2. MIPS Performance

CMS evaluates clinician performance based on the measures and activities reported or calculated for the MIPS quality, cost, improvement activities and Promoting Interoperability performance categories.

- **The quality performance category** measures performance on clinical practices and patient outcomes. Quality measures are tools used to assess healthcare processes, outcomes, and patient experiences to ensure that they align with CMS quality goals for healthcare. In traditional MIPS, clinicians select their measures from the full inventory of available measures, choosing those most applicable to their patient population and scope of care.
- **The cost performance category** measures a healthcare provider's ability to manage healthcare expenses while providing high-quality care. In 2022, the cost performance category is worth 30% of the final MIPS score. Although clinicians don't personally determine the price of individual services provided to Medicare patients, they can affect the amount and types of services provided. By better coordinating care and seeking to improve health outcomes by ensuring that their patients receive the right services, clinicians play a meaningful role in delivering high-quality care at a reasonable cost. In traditional MIPS, clinicians are assessed on the cost measures for which they meet requirements.
- **The improvement activities performance category** assesses participation in clinical activities that support the improvement of clinical practice, care delivery, and outcomes. In traditional MIPS, clinicians select activities from the full inventory of activities, choosing those that best fit their practice and support the needs of patients by improving patient engagement, care coordination, patient safety, and other areas in patient care.
- **The Promoting Interoperability performance category** measures the use of technology to exchange and make use of information, with the goal of making communicating patient information less burdensome and improving outcomes. The MIPS Promoting Interoperability performance category emphasizes the electronic exchange of health information using Certified Electronic Health Record Technology (CEHRT) to improve patient access to their health information; the exchange of information between clinicians and pharmacies; and the systematic collection, analysis, and interpretation of healthcare data. Clinicians report a defined set of measures, many of which have one or more exclusions available.

For more information about the 4 MIPS performance categories, review the additional resources in the Appendix.

Key Insights

2.1 Quality Performance Category¹⁹

Table 11. 20 Most Frequently Used Quality Measures in 2022 (Excluding Qualified Clinical Data Registry (QCDR) Measures)

- The top 2 most frequently used quality measures are administrative claims measures, which are automatically attributed to clinicians and calculated by CMS.
- There are no MIPS clinical quality measures (CQMs) on the list of most frequently reported measures; the most frequently used measures submitted by clinicians are the CAHPS for MIPS Survey measure, CMS Web Interface measures, and electronic CQMs (eCQMs).
- The prevalence of CMS Web Interface measures and the CAHPS for MIPS Survey measure is likely attributed to their inclusion in the APP quality measure set, which Shared Savings Program Accountable Care Organizations [ACOs] are required to report.

Quality ID	Collection Type ²⁰	Measure Name	Measure's First Year in Program	Number of Clinicians Scored on the Measure	Percentage of Clinicians Scored on the Measure (Out of All MIPS Eligible Clinicians Scored on Quality)	Mean Measure Score	10 th Percentile Measure Score	50 th Percentile Measure Score (Median)	90 th Percentile Measure Score
484	Administrative Claims	Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions	2022	366,426	67.55%	5.48	3.00	5.27	8.99
479	Administrative Claims	Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Groups	2021	363,832	67.07%	6.17	3	6.2129	9.4789
321	CAHPS	CAHPS for MIPS Clinician/Group Survey	2017	166,288	30.65%	6.01	4.08	5.93	7.78
110	CMS Web Interface	Preventive Care and Screening: Influenza Immunization	2017	165,640	30.53%	8.74	7.57	8.90	9.84

¹⁹ This data reflects the quality measures that contributed to a MIPS eligible clinician's final score, excluding measures that were suppressed for the 2022 performance year. A quality measure that was submitted but not used in final scoring wouldn't be eligible to contribute to the data in these tables. Measure data is broken out by collection type, which means that the same measure (as identified by ID) can appear in the same table under different collection types. (For example, measures 112 and 318 appear in Table 11 twice; once as a CMS Web Interface measure, and separately as an electronic clinical quality measure (eCQM).)

²⁰ **Collection type** refers to the way you collect data for a MIPS quality measure. While an individual MIPS quality measure may be collected in multiple ways, each collection type has its own specification (instructions) for reporting that measure. More information about collection types is available beginning on p. 20 of the [2022 MIPS Quality User Guide \(PDF, 1MB\)](#).

Quality ID	Collection Type ²⁰	Measure Name	Measure's First Year in Program	Number of Clinicians Scored on the Measure	Percentage of Clinicians Scored on the Measure (Out of All MIPS Eligible Clinicians Scored on Quality)	Mean Measure Score	10 th Percentile Measure Score	50 th Percentile Measure Score (Median)	90 th Percentile Measure Score
318	CMS Web Interface	Falls: Screening for Future Fall Risk	2017	165,640	30.53%	9.64	8.40	10.00	10.00
226	CMS Web Interface	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	2017	165,615	30.53%	8.56	6.83	8.73	10.00
112	CMS Web Interface	Breast Cancer Screening	2017	165,615	30.53%	8.86	7.71	9.06	9.66
134	CMS Web Interface	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	2017	165,615	30.53%	8.51	6.66	8.81	9.98
113	CMS Web Interface	Colorectal Cancer Screening	2017	165,615	30.53%	8.54	7.65	8.63	9.55
236	CMS Web Interface	Controlling High Blood Pressure	2017	165,615	30.53%	8.32	7.69	8.31	9.03
001	CMS Web Interface	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	2017	165,615	30.53%	9.86	9.51	10.00	10.00
480	Administrative Claims	Risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) for MIPS	2021	121,657	22.43%	5.98	3.00	6.34	9.68
001	eCQM	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	2017	107,776	19.87%	7.40	5.52	7.68	8.76
309	eCQM	Cervical Cancer Screening	2017	62,116	11.45%	8.71	7.24	8.86	10.00
318	eCQM	Falls: Screening for Future Fall Risk	2017	53,396	9.84%	8.24	6.37	8.17	10.00
475	eCQM	HIV Screening	2019	48,126	8.87%	9.33	7.97	10.00	10.00

Quality ID	Collection Type ²⁰	Measure Name	Measure's First Year in Program	Number of Clinicians Scored on the Measure	Percentage of Clinicians Scored on the Measure (Out of All MIPS Eligible Clinicians Scored on Quality)	Mean Measure Score	10 th Percentile Measure Score	50 th Percentile Measure Score (Median)	90 th Percentile Measure Score
438	eCQM	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	2017	46,583	8.59%	8.43	6.62	8.65	10.00
112	eCQM	Breast Cancer Screening	2017	45,391	8.37%	8.05	5.78	8.37	9.64
305	eCQM	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	2017	45,366	8.36%	9.03	7.93	9.24	10.00
111	eCQM	Pneumococcal Vaccination Status for Older Adults	2017	38,198	7.04%	7.75	5.33	8.10	9.70

Table 12. 20 Most Frequently Used QCDR (Quality) Measures in 2022

- The most frequently used QCDR measure was included in the final score of less than 2% of MIPS eligible clinicians.

Quality ID	Measure Name	Measure's First Year in Program	Number of Clinicians Scored on the Measure	Percentage of Clinicians Scored on the Measure (Out of All MIPS Eligible Clinicians Scored on Quality)	Mean Measure Score	10 th Percentile Measure Score	50 th Percentile Measure Score (Median)	90 th Percentile Measure Score
ECPR39	Avoid Head CT for Patients with Uncomplicated Syncope	2016	10,707	1.97%	8.68	6.82	8.89	10.00
AQI48	Patient-Reported Experience with Anesthesia	2017	9,271	1.71%	8.62	7.07	9.23	9.85
AQI63	Obstructive Sleep Apnea: Mitigation Strategies	2020	8,709	1.61%	8.05	5.25	8.71	10.00
ECPR46	Avoidance of Opiates for Low Back Pain or Migraines	2018	8,178	1.51%	9.35	8.45	10.00	10.00
AQI72	Perioperative Anemia Management	2021	7,914	1.46%	9.66	10.00	10.00	10.00
AQI73	Prevention of Arterial Line-Related Bloodstream Infections	2022	6,056	1.12%	9.26	7.00	10.00	10.00
ABG43	Use of Capnography for Non-Operating Room Anesthesia Measure	2022	5,515	1.02%	7.26	7.00	7.00	8.22

Quality ID	Measure Name	Measure's First Year in Program	Number of Clinicians Scored on the Measure	Percentage of Clinicians Scored on the Measure (Out of All MIPS Eligible Clinicians Scored on Quality)	Mean Measure Score	10 th Percentile Measure Score	50 th Percentile Measure Score (Median)	90 th Percentile Measure Score
QUANTUM31	Central Line Ultrasound Guidance	2016	5,337	0.98%	6.28	4.96	7.00	7.00
PQRANES1	Use of Peripheral Nerve Block within the Emergency Department in Patients Admitted with Low Energy Hip Fracture	2022	5,257	0.97%	7.69	7.00	7.00	9.70
ACQR3	COPD: Steroids for No More than 5 days in COPD Exacerbation	2018	4,552	0.84%	5.56	3.00	5.18	8.96
KEET01	Failure to Progress (FTP): Proportion of patients failing to achieve a Minimal Clinically Important Difference (MCID) to indicate functional improvement in rehabilitation of patients with neck pain/injury measured via the validated Neck Disability Index (NDI).	2022	4,465	0.82%	7.88	7.00	7.28	10.00
AQI62	Obstructive Sleep Apnea: Patient Education	2019	4,454	0.82%	6.54	5.78	6.70	6.95
AQI56	Use of Neuraxial Techniques and/or Peripheral Nerve Blocks for Total Knee Arthroplasty (TKA)	2018	4,216	0.78%	5.98	3.84	6.56	7.00
ACEP59	Chest Pain – Avoidance of Admission for Adult Patients with Low-Risk Chest Pain	2022	4,192	0.77%	7.76	7.00	7.00	9.85
ACEP22	Appropriate Emergency Department Utilization of CT for Pulmonary Embolism	2016	4,085	0.75%	9.65	8.87	10.00	10.00
MSN15	Use of Thyroid Imaging Reporting & Data System (TI-RADS) in Final Report to Stratify Thyroid Nodule Risk	2020	4,065	0.75%	9.93	10.00	10.00	10.00
IRIS59	Regaining Vision After Cataract Surgery	2020	4,020	0.74%	9.62	8.32	10.00	10.00
ACEP21	Coagulation Studies in Patients Presenting with Chest Pain with No Coagulopathy or Bleeding	2016	3,901	0.72%	8.78	7.85	8.89	9.57

Quality ID	Measure Name	Measure's First Year in Program	Number of Clinicians Scored on the Measure	Percentage of Clinicians Scored on the Measure (Out of All MIPS Eligible Clinicians Scored on Quality)	Mean Measure Score	10 th Percentile Measure Score	50 th Percentile Measure Score (Median)	90 th Percentile Measure Score
AQI69	Intraoperative Antibiotic Redosing	2021	3,891	0.72%	7.72	5.00	6.69	10.00
IROMS17	Failure to Progress (FTP): Proportion of Patients Failing to Achieve a Minimal Clinically Important Difference (MCID) to Indicate Functional Improvement in Rehabilitation Patients with Low Back Pain Measured via the Validated Modified Low Back Pain Disability Questionnaire (MDQ) Score.	2019	3,802	0.70%	8.35	5.14	8.82	10.00

Table 13. 20 Least Frequently Used Quality Measures in 2022 (Excluding QCDR Measures)²¹

- As expected, the least frequently reported measures generally have a mean measure score of 3 points, the scoring floor in the 2022 performance year for quality measures without a benchmark. (Only one of the 20 least frequently used measures had a benchmark.)

Quality ID	Collection Type	Measure Name	Measure's First Year in Program	Number of Clinicians Scored on the Measure	Percentage of Clinicians Scored on the Measure (Out of All MIPS Eligible Clinicians Scored on Quality)	Mean Measure Score	10 th Percentile Measure Score	50 th Percentile Measure Score (Median)	90 th Percentile Measure Score
336	MIPS CQM	Maternity Care: Postpartum Follow-up and Care Coordination	2017	1	0.0002%	3.00	3.00	3.00	3.00
448	MIPS CQM	Appropriate Workup Prior to Endometrial Ablation	2017	1	0.0002%	3.00	3.00	3.00	3.00
455	MIPS CQM	Percentage of Patients Who Died from Cancer Admitted to the Intensive Care Unit (ICU) in the Last 30 Days of Life (lower score - better)	2017	1	0.0002%	3.00	3.00	3.00	3.00
461	MIPS CQM	Leg Pain After Lumbar Discectomy/Laminectomy	2018	1	0.0002%	3.00	3.00	3.00	3.00
587	MIPS CQM	Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users	2017	2	0.0004%	3.00	3.00	3.00	3.00

²¹ This data was sorted by Percentage of Clinicians Scored on the Measure (smallest to largest) and then by Quality ID (smallest to largest).

Quality ID	Collection Type	Measure Name	Measure's First Year in Program	Number of Clinicians Scored on the Measure	Percentage of Clinicians Scored on the Measure (Out of All MIPS Eligible Clinicians Scored on Quality)	Mean Measure Score	10 th Percentile Measure Score	50 th Percentile Measure Score (Median)	90 th Percentile Measure Score
391	MIPS CQM	Follow-Up After Hospitalization for Mental Illness (FUH)	2017	2	0.0004%	3.00	3.00	3.00	3.00
422	Medicare Part B Claims	Performing Cystoscopy at the Time of Hysterectomy for Pelvic Organ Prolapse to Detect Lower Urinary Tract Injury	2017	2	0.0004%	3.00	3.00	3.00	3.00
392	MIPS CQM	Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation Ablation	2017	3	0.0006%	3.00	3.00	3.00	3.00
393	MIPS CQM	Infection within 180 Days of Cardiac Implantable Electronic Device (CIED) Implantation, Replacement, or Revision	2017	3	0.0006%	3.00	3.00	3.00	3.00
304	MIPS CQM	Cataracts: Patient Satisfaction within 90 Days Following Cataract Surgery	2017	4	0.0007%	3.00	3.00	3.00	3.00
378 ²²	eCQM	Children Who Have Dental Decay or Cavities	2017	4	0.0007%	8.25	5.10	10.00	10.00
460	MIPS CQM	Back Pain After Lumbar Fusion	2018	4	0.0007%	3.00	3.00	3.00	3.00
258	MIPS CQM	Rate of Open Repair of Small or Moderate Non-Ruptured Infrarenal Abdominal Aortic Aneurysms (AAA) without Major Complications (Discharged to Home by Post-Operative Day #7)	2017	5	0.0009%	3.00	3.00	3.00	3.00
422	MIPS CQM	Performing Cystoscopy at the Time of Hysterectomy for Pelvic Organ Prolapse to Detect Lower Urinary Tract Injury	2017	5	0.0009%	3.00	3.00	3.00	3.00

²² Measure had a historical benchmark, making it eligible to earn more points than the scoring floor.

Quality ID	Collection Type	Measure Name	Measure's First Year in Program	Number of Clinicians Scored on the Measure	Percentage of Clinicians Scored on the Measure (Out of All MIPS Eligible Clinicians Scored on Quality)	Mean Measure Score	10 th Percentile Measure Score	50 th Percentile Measure Score (Median)	90 th Percentile Measure Score
433	MIPS CQM	Proportion of Patients Sustaining a Bowel Injury at the time of any Pelvic Organ Prolapse Repair	2017	5	0.0009%	3.00	3.00	3.00	3.00
459	MIPS CQM	Back Pain After Lumbar Discectomy/Laminectomy	2018	5	0.0009%	3.00	3.00	3.00	3.00
386	MIPS CQM	Amyotrophic Lateral Sclerosis (ALS) Patient Care Preferences	2017	6	0.0011%	3.00	3.00	3.00	3.00
401	MIPS CQM	Hepatitis C: Screening for Hepatocellular Carcinoma (HCC) in Patients with Cirrhosis	2017	7	0.0013%	3.00	3.00	3.00	3.00
261	MIPS CQM	Referral for Otologic Evaluation for Patients with Acute or Chronic Dizziness	2017	8	0.0015%	3.00	3.00	3.00	3.00
409	MIPS CQM	Clinical Outcome Post Endovascular Stroke Treatment	2017	8	0.0015%	3.00	3.00	3.00	3.00

Table 14. 20 Least Frequently Used QCDR (Quality) Measures in 2022²³

- The mean performance score for the least frequently reported QCDR measures was generally the scoring floor for measures without a benchmark: 7 points for measures in their first year in the program (added in 2022), 5 points for measures in their second year in the program (added in 2021), and 3 points for measures in their third year in the program or later.

Quality ID	Measure Name	Measure's First Year in Program	Number of Clinicians Scored on the Measure	Percentage of Clinicians Scored on the Measure (Out of All MIPS Eligible Clinicians Scored on Quality)	Mean Measure Score	10 th Percentile Measure Score	50 th Percentile Measure Score (Median)	90 th Percentile Measure Score
AAN28	Diabetes/Pre-Diabetes Screening for Patients with DSP	2020	1	0.0002%	3.00	3.00	3.00	3.00

²³ This data was sorted by Percentage of Clinicians Scored on the Measure (smallest to largest) and then by Quality ID (A to Z).

Quality ID	Measure Name	Measure's First Year in Program	Number of Clinicians Scored on the Measure	Percentage of Clinicians Scored on the Measure (Out of All MIPS Eligible Clinicians Scored on Quality)	Mean Measure Score	10 th Percentile Measure Score	50 th Percentile Measure Score (Median)	90 th Percentile Measure Score
AAO32	Standard Benign Positional Paroxysmal Vertigo (BPPV) Management	2019	1	0.0002%	3.00	3.00	3.00	3.00
ABG40	Hypotension Prevention After Spinal Placement for Elective Cesarean Section	2021	1	0.0002%	5.00 ²⁴	5.00	5.00	5.00
ACR16	Rheumatoid Arthritis Patients with Low Disease Activity or Remission	2021	1	0.0002%	3.00	3.00	3.00	3.00
IGR15	Myocardial Perfusion Imaging (MPI) or Stress Echocardiography Imaging Studies - Adequate Exercise Protocol	2021	1	0.0002%	5.00	5.00	5.00	5.00
IGR16	Myocardial Perfusion Imaging (MPI) Studies, Transthoracic Echo (TTE), or Stress Echocardiography Imaging Studies - Adequate Reporting for Appropriate Interventions	2021	1	0.0002%	5.00	5.00	5.00	5.00
IGR18	Myocardial Perfusion Imaging (MPI) or Stress Echocardiography imaging studies - Improving Image Quality	2021	1	0.0002%	5.00	5.00	5.00	5.00
MBHR17	Improved Efficiency: Time Interval for reporting results of cognitive assessment	2022	1	0.0002%	7.00 ²⁵	7.00	7.00	7.00
OEIS7	Structured Walking Program Prior to Intervention for Claudication	2019	1	0.0002%	3.00	3.00	3.00	3.00
ASPS22	Coordination of Care for Anticoagulated Patients Undergoing Reconstruction After Skin Cancer Resection	2020	2	0.0004%	3.00	3.00	3.00	3.00

²⁴ Beginning with the 2022 performance year, quality measures in their 2nd year of the program have a 5-point scoring floor if data completeness criteria are met.

²⁵ Beginning with the 2022 performance year, quality measures in their 1st year of the program have a 7-point scoring floor if data completeness criteria are met.

Quality ID	Measure Name	Measure's First Year in Program	Number of Clinicians Scored on the Measure	Percentage of Clinicians Scored on the Measure (Out of All MIPS Eligible Clinicians Scored on Quality)	Mean Measure Score	10 th Percentile Measure Score	50 th Percentile Measure Score (Median)	90 th Percentile Measure Score
HM11	Outcomes of Treatment of Subjective Tinnitus	2021	2	0.0004%	5.00	5.00	5.00	5.00
AAN30	Migraine Preventive Therapy Management	2021	3	0.0006%	5.00	5.00	5.00	5.00
ACMS9	Post-Operative Management of Field Cancerization after Mohs Micrographic Surgery	2022	3	0.0006%	3.00	3.00	3.00	3.00
CDR2 ²⁶	Diabetic Foot Ulcer (DFU) Healing or Closure	2014	3	0.0006%	8.49	6.37	10.00	10.00
OE158	Use of ultrasound guidance for vascular access	2020	3	0.0006%	3.00	3.00	3.00	3.00
AAAA118	Penicillin Allergy: Appropriate Removal or Confirmation	2015	4	0.0007%	3.00	3.00	3.00	3.00
AAD10	Dermatitis – Improvement in Patient-Reported Itch Severity	2020	4	0.0007%	3.00	3.00	3.00	3.00
AAO36	Tympanostomy Tubes: Resolution of Otitis Media with Effusion (OME) in Adults and Children	2020	4	0.0007%	3.00	3.00	3.00	3.00
CDR6 ²³	Venous Leg Ulcer (VLU) Healing or Closure	2014	5	0.0009%	7.10	4.29	6.86	10.00
IRIS6	Acquired Involitional Entropion: Normalized lid position after surgical repair	2015	6	0.0011%	3.00	3.00	3.00	3.00

²⁶ Measure had a historical benchmark, making it eligible for more points than the scoring floor.

Table 15. 20 Highest Scoring Quality Measures in 2022 (Excluding QCDR Measures)

Quality ID	Collection Type	Measure Name	Measure's First Year in Program	Number of Clinicians Scored on the Measure	Percentage of Clinicians Scored on the Measure (Out of All MIPS Eligible Clinicians Scored on Quality) ²⁷	Mean Measure Score	10 th Percentile Measure Score	50 th Percentile Measure Score (Median)	90 th Percentile Measure Score
001	CMS Web Interface	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	2017	165,615	30.53%	9.86	9.51	10.00	10.00
318	CMS Web Interface	Falls: Screening for Future Fall Risk	2017	165,640	30.53%	9.64	8.40	10.00	10.00
475	eCQM	HIV Screening	2019	48,126	8.87%	9.33	7.97	10.00	10.00
305	eCQM	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	2017	45,366	8.36%	9.03	7.93	9.24	10.00
331	MIPS CQM	Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse)	2017	18,179	3.35%	8.94	7.17	9.64	10.00
370	eCQM	Depression Remission at Twelve Months	2017	22,659	4.18%	8.90	7.10	9.14	10.00
112	CMS Web Interface	Breast Cancer Screening	2017	165,615	30.53%	8.86	7.71	9.06	9.66
110	CMS Web Interface	Preventive Care and Screening: Influenza Immunization	2017	165,640	30.53%	8.74	7.57	8.90	9.84
309	eCQM	Cervical Cancer Screening	2017	62,116	11.45%	8.71	7.24	8.86	10.00
007	eCQM	Coronary Artery Disease (CAD): Beta-Blocker Therapy - Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%)	2017	16,973	3.13%	8.58	7.19	8.66	10.00
226	CMS Web Interface	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	2017	165,615	30.53%	8.56	6.83	8.73	10.00

²⁷ A 2% minimum reporting threshold was applied to this table; data is limited to measures that contributed to the final score of at least 2% of clinicians.

Quality ID	Collection Type	Measure Name	Measure's First Year in Program	Number of Clinicians Scored on the Measure	Percentage of Clinicians Scored on the Measure (Out of All MIPS Eligible Clinicians Scored on Quality) ¹⁷	Mean Measure Score	10 th Percentile Measure Score	50 th Percentile Measure Score (Median)	90 th Percentile Measure Score
113	CMS Web Interface	Colorectal Cancer Screening	2017	165,615	30.53%	8.54	7.65	8.63	9.55
134	CMS Web Interface	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	2017	165,615	30.53%	8.51	6.66	8.81	9.98
107	eCQM	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	2017	14,110	2.60%	8.50	7.31	8.49	9.98
066	MIPS CQM	Appropriate Testing for Pharyngitis	2017	12,254	2.26%	8.49	5.71	8.85	10.00
117	eCQM	Diabetes: Eye Exam	2017	14,373	2.65%	8.46	6.56	8.93	10.00
438	eCQM	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	2017	46,583	8.59%	8.43	6.62	8.65	10.00
317	eCQM	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	2017	30,606	5.64%	8.41	6.81	8.65	10.00
128	MIPS CQM	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	2017	11,661	2.15%	8.38	4.75	10.00	10.00
310	eCQM	Chlamydia Screening for Women	2017	29,310	5.40%	8.38	6.97	8.27	10.00

Table 16. 20 Highest Scoring QCDR (Quality) Measures in 2022

There are no QCDR measures that met the 2% reporting threshold for inclusion in this table. Refer to [Table 12](#) for the most frequently reported QCDR measures, including measure score information.

Table 17. 20 Lowest Scoring Quality Measures in 2022 (Excluding QCDR Measures)²⁸

Quality ID	Collection Type	Measure Name	Measure's First Year in Program	Number of Clinicians Scored on the Measure	Percentage of Clinicians Scored on the Measure (Out of All MIPS Eligible ²⁹)	Mean Measure Score	10 th Percentile Measure Score	50 th Percentile Measure Score (Median)	90 th Percentile Measure Score
484	Administrative Claims	Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions	2022	366,426	67.55%	5.48	3.00	5.27	8.99
130	eCQM	Documentation of Current Medications in the Medical Record	2017	24,445	4.51%	5.72	3.00	6.83	7.00
480	Administrative Claims	Risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) for MIPS	2021	121,657	22.43%	5.98	3.00	6.34	9.68
321	CAHPS for MIPS Survey	CAHPS for MIPS Clinician/Group Survey	2017	166,288	30.65%	6.01	4.08	5.93	7.78
479	Administrative Claims	Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Groups	2021	363,832	67.07%	6.17	3.00	6.21	9.48
130	MIPS CQM	Documentation of Current Medications in the Medical Record	2017	24,295	4.48%	6.29	3.92	7.00	7.00

²⁸ Table 17 includes the 20 lowest scoring quality measures from 2022, as determined by the mean score. Measures with the same mean score were further sorted in descending order by the percentage of clinicians measured. QCDR measures are excluded from Table 17 and can be found in Table 18.

²⁹ A 2% minimum reporting threshold was applied to this table; data is limited to measures that contributed to the final score of at least 2% of clinicians.

Quality ID	Collection Type	Measure Name	Measure's First Year in Program	Number of Clinicians Scored on the Measure	Percentage of Clinicians Scored on the Measure (Out of All MIPS Eligible ²³ Clinicians Scored on Quality)	Mean Measure Score	10 th Percentile Measure Score	50 th Percentile Measure Score (Median)	90 th Percentile Measure Score
076	MIPS CQM	Prevention of Central Venous Catheter (CVC) - Related Bloodstream Infections	2017	19,024	3.51%	6.36	3.83	7.00	7.00
404	MIPS CQM	Anesthesiology Smoking Abstinence	2017	12,759	2.35%	7.02	4.79	7.17	9.40
001	eCQM	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	2017	107,776	19.87%	7.40	5.52	7.68	8.76
191	eCQM	Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery	2017	14,033	2.59%	7.41	5.53	7.59	10.00
119	eCQM	Diabetes: Medical Attention for Nephropathy	2017	20,459	3.77%	7.45	4.73	7.77	9.77
236	MIPS CQM	Controlling High Blood Pressure	2017	14,838	2.74%	7.69	6.15	7.72	9.47
111	eCQM	Pneumococcal Vaccination Status for Older Adults	2017	38,198	7.04%	7.75	5.33	8.10	9.70
066	eCQM	Appropriate Testing for Pharyngitis	2017	17,776	3.28%	7.88	6.07	8.05	9.44
226	eCQM	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	2017	22,834	4.21%	7.94	5.19	8.39	10.00
112	eCQM	Breast Cancer Screening	2017	45,391	8.37%	8.05	5.78	8.37	9.64
047	MIPS CQM	Advance Care Plan	2017	29,936	5.52%	8.08	5.76	8.28	10.00
065	eCQM	Appropriate Treatment for Upper Respiratory Infection (URI)	2017	35,314	6.51%	8.10	5.89	8.29	9.73
318	eCQM	Falls: Screening for Future Fall Risk	2017	53,396	9.84%	8.24	6.37	8.17	10.00

Quality ID	Collection Type	Measure Name	Measure's First Year in Program	Number of Clinicians Scored on the Measure	Percentage of Clinicians Scored on the Measure (Out of All MIPS Eligible ²⁹ Clinicians Scored on Quality)	Mean Measure Score	10 th Percentile Measure Score	50 th Percentile Measure Score (Median)	90 th Percentile Measure Score
374	eCQM	Closing the Referral Loop: Receipt of Specialist Report	2017	19,650	3.62%	8.26	6.34	8.55	10.00

Table 18. 20 Lowest Scoring QCDR (Quality) Measures in 2022

There are no QCDR measures that met the 2% threshold for inclusion in this table. Refer to **Table 14** for the least frequently reported QCDR measures, including measure score information.

Table 19a. Top 2 Most Frequently Reported Quality Measures per Specialty

- Except for Optometrists and Ophthalmologists, administrative claims measures (which are automatically calculated) were those most frequently contributing to the quality score of the specialties listed below.

Specialty ³⁰	Most Frequently Reported Quality Measure					Second Most Frequently Reported Quality Measure				
	Quality ID	Measure Name	Collection Type	Number of Clinicians Scored on the Measure	Percentage of Clinicians within the Specialty Who Reported the Measure	Quality ID	Measure Name	Collection Type	Number of Clinicians Scored on the Measure	Percentage of Clinicians within the Specialty Who Reported the Measure
Internal Medicine	479	Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Groups	Administrative Claims	33,006	80.32%	484	Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions (MCC)	Administrative Claims	30,727	74.77%
Family Medicine	484	MCC	Administrative Claims	27,652	80.42%	479	HWR	Administrative Claims	27,306	79.42%

³⁰ This table is limited to the 20 specialties with the greatest number of MIPS eligible clinicians in the 2022 performance year.

Specialty ³⁰	Most Frequently Reported Quality Measure					Second Most Frequently Reported Quality Measure				
	Quality ID	Measure Name	Collection Type	Number of Clinicians Scored on the Measure	Percentage of Clinicians within the Specialty Who Reported the Measure	Quality ID	Measure Name	Collection Type	Number of Clinicians Scored on the Measure	Percentage of Clinicians within the Specialty Who Reported the Measure
Emergency Medicine	479	HWR	Administrative Claims	18,161	64.79%	484	MCC	Administrative Claims	12,045	42.97%
Diagnostic Radiology	484	MCC	Administrative Claims	11,205	41.92%	479	HWR	Administrative Claims	11,085	41.47%
Anesthesiology	484	MCC	Administrative Claims	8,637	47.46%	479	HWR	Administrative Claims	8,336	45.80%
Orthopedic Surgery	484	MCC	Administrative Claims	8,749	70.84%	479	HWR	Administrative Claims	8,633	69.90%
Cardiology	484	MCC	Administrative Claims	9,618	75.73%	479	HWR	Administrative Claims	9,463	74.51%
Ophthalmology	117	Diabetes: Eye Exam	eCQM	5,903	49.94%	238	Use of High-Risk Medications in Older Adults	eCQM	4,161	35.20%
Obstetrics/Gynecology	484	MCC	Administrative Claims	11,023	85.24%	479	HWR	Administrative Claims	10,208	78.94%
General Surgery	484	MCC	Administrative Claims	9,445	83.30%	479	HWR	Administrative Claims	9,375	82.68%
Hospitalist	479	HWR	Administrative Claims	10,589	94.02%	484	MCC	Administrative Claims	9,215	81.82%
Neurology	484	MCC	Administrative Claims	7,611	81.32%	479	HWR	Administrative Claims	7,336	78.38%

Specialty ³⁰	Most Frequently Reported Quality Measure					Second Most Frequently Reported Quality Measure				
	Quality ID	Measure Name	Collection Type	Number of Clinicians Scored on the Measure	Percentage of Clinicians within the Specialty Who Reported the Measure	Quality ID	Measure Name	Collection Type	Number of Clinicians Scored on the Measure	Percentage of Clinicians within the Specialty Who Reported the Measure
Gastroenterology	484	MCC	Administrative Claims	5,755	76.84%	479	HWR	Administrative Claims	5,682	75.86%
Dermatology	484	MCC	Administrative Claims	2,740	43.87%	137	Melanoma: Continuity of Care - Recall System	MIPS CQMs	2,390	38.26%
Podiatry	484	MCC	Administrative Claims	2,054	32.69%	479	HWR	Administrative Claims	1,826	29.06%
Psychiatry	484	MCC	Administrative Claims	6,199	81.21%	479	HWR	Administrative Claims	5,723	74.98%
Pathology	484	MCC	Administrative Claims	3,903	51.67%	479	HWR	Administrative Claims	3,860	51.11%
Optometry	117	Diabetes: Eye Exam	eCQM	3,788	57.13%	238	Use of High-Risk Medications in Older Adults	eCQM	2,663	40.17%
Pulmonary Disease	484	MCC	Administrative Claims	4,949	79.44%	479	HWR	Administrative Claims	4,863	78.06%
Urology	484	MCC	Administrative Claims	4,297	75.53%	479	HWR	Administrative Claims	4,050	71.19%

Table 19b. Top 2 Most Frequently Reported Quality Measures by Specialty – Excluding Administrative Claims³¹

Specialty ³²	Most Frequently Reported Quality Measure					Second Most Frequently Reported Quality Measure				
	Quality ID	Measure Name	Collection Type	Number of Clinicians Scored on the Measure	Percentage of Clinicians within the Specialty Who Reported the Measure	Quality ID	Measure Name	Collection Type	Number of Clinicians Scored on the Measure	Percentage of Clinicians within the Specialty Who Reported the Measure
Internal Medicine	110	Preventive Care and Screening: Influenza Immunization	CMS Web Interface	14,630	35.601%	318	Falls: Screening for Future Fall Risk	CMS Web Interface	14,630	35.60%
Family Medicine	110	Preventive Care and Screening: Influenza Immunization	CMS Web Interface	14,506	42.190%	318	Falls: Screening for Future Fall Risk	CMS Web Interface	14,506	42.19%
Emergency Medicine	331	Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse)	MIPS CQM	9,618	34.312%	066	Appropriate Testing for Pharyngitis	MIPS CQM	7,187	25.64%
Diagnostic Radiology	145	Radiology: Exposure Dose Indices or Exposure Time and Number of Images Reported for Procedures Using Fluoroscopy	MIPS CQM	7,993	29.906%	147	Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy	MIPS CQM	7,052	26.39%
Anesthesiology	404	Anesthesiology Smoking Abstinence	MIPS CQM	5,015	27.555%	477	Multimodal Pain Management	MIPS CQM	4,236	23.27%
Orthopedic Surgery	110	Preventive Care and Screening: Influenza Immunization	CMS Web Interface	3,726	30.168%	318	Falls: Screening for Future Fall Risk	CMS Web Interface	3,726	30.17%
Cardiology	321	CAHPS for MIPS Clinician/Group Survey	CAHPS for MIPS Survey	4,935	38.855%	001	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	CMS Web Interface	4,930	38.82%

³¹ Table 19b provides the top 2 measures attributed to clinicians in each specialty, based on the measures selected and submitted by the practice.³² This table is limited to the 20 specialties with the greatest number of MIPS eligible clinicians in the 2022 performance year.

Specialty ²²	Most Frequently Reported Quality Measure					Second Most Frequently Reported Quality Measure				
	Quality ID	Measure Name	Collection Type	Number of Clinicians Scored on the Measure	Percentage of Clinicians within the Specialty Who Reported the Measure	Quality ID	Measure Name	Collection Type	Number of Clinicians Scored on the Measure	Percentage of Clinicians within the Specialty Who Reported the Measure
Ophthalmology	117	Diabetes: Eye Exam	eCQM	5,903	49.937%	238	Use of High-Risk Medications in Older Adults	eCQM	4,161	35.20%
Obstetrics/Gynecology	001	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	CMS Web Interface	4,939	38.192%	110	Preventive Care and Screening: Influenza Immunization	CMS Web Interface	4,939	38.19%
General Surgery	321	CAHPS for MIPS Clinician/Group Survey	CAHPS for MIPS Survey	4,722	41.644%	001	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	CMS Web Interface	4,665	41.14%
Hospitalist	001	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	CMS Web Interface	5,231	46.444%	110	Preventive Care and Screening: Influenza Immunization	CMS Web Interface	5,231	46.44%
Neurology	321	CAHPS for MIPS Clinician/Group Survey	CAHPS for MIPS Survey	3,373	36.040%	110	Preventive Care and Screening: Influenza Immunization	CMS Web Interface	3,350	35.79%
Gastroenterology	321	CAHPS for MIPS Clinician/Group Survey	CAHPS for MIPS Survey	2,953	39.426%	001	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	CMS Web Interface	2,632	35.14%
Dermatology	137	Melanoma: Continuity of Care - Recall System	MIPS CQM	2,390	38.265%	410	Psoriasis: Clinical Response to Systemic Medications	MIPS CQM	1,754	28.08%
Podiatry	236	Controlling High Blood Pressure	eCQM	1,208	19.227%	001	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	eCQM	1,166	18.56%

Specialty ³²	Most Frequently Reported Quality Measure					Second Most Frequently Reported Quality Measure				
	Quality ID	Measure Name	Collection Type	Number of Clinicians Scored on the Measure	Percentage of Clinicians within the Specialty Who Reported the Measure	Quality ID	Measure Name	Collection Type	Number of Clinicians Scored on the Measure	Percentage of Clinicians within the Specialty Who Reported the Measure
Psychiatry	001	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	CMS Web Interface	2,603	34.102%	110	Preventive Care and Screening: Influenza Immunization	CMS Web Interface	2,603	34.10%
Pathology	395	Lung Cancer Reporting (Biopsy/Cytology Specimens)	MIPS CQM	2,232	29.551%	396	Lung Cancer Reporting (Resection Specimens)	MIPS CQM	2,195	29.06%
Optometry	117	Diabetes: Eye Exam	eCQM	3,788	57.134%	238	Use of High-Risk Medications in Older Adults	eCQM	2,663	40.17%
Pulmonary Disease	321	CAHPS for MIPS Clinician/Group Survey	CAHPS for MIPS Survey	2,391	38.379%	001	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	CMS Web Interface	2,369	38.03%
Urology	321	CAHPS for MIPS Clinician/Group Survey	CAHPS for MIPS Survey	1,995	35.068%	110	Preventive Care and Screening: Influenza Immunization	CMS Web Interface	1,944	34.17%

2.2 Cost Performance Category

Table 20. Cost Measure Performance in 2022 (All Measures)

- It's not surprising that the 2 population-based cost measures – Total Per Capita Cost (TPCC) and Medicare Spending Per Beneficiary (MSPB) Clinician measures – were applicable to the greatest percentage of MIPS eligible clinicians who received a score in the cost performance category:
 - More than 90% of these clinicians were scored on the TPCC measure, whereas approximately 73% of these clinicians received a score on MSPB Clinician measure.

Measure ID	Measure Name	Number of MIPS Eligible Clinicians Scored on the Measure	Percentage of MIPS Eligible Clinicians Scored on the Measure (Out of All MIPS Eligible Clinicians Scored on Cost)	Mean Measure Score	10 th Percentile Measure Score	50 th Percentile Measure Score (Median)	90 th Percentile Measure Score
TPCC_1	Total Per Capita Cost (TPCC)	243,811	90.29%	5.11	1.88	5.00	8.60
MSPB_1	Medicare Spending Per Beneficiary (MSPB) Clinician	197,927	73.30%	7.43	4.70	7.56	9.95
COST_D_1	Diabetes	196,534	72.78%	5.00	2.67	4.99	7.56
COST_ACOPD_1	Asthma/Chronic Obstructive Pulmonary Disease (COPD)	170,776	63.24%	4.20	2.06	3.87	6.54
COST_S_1	Sepsis	153,659	56.90%	8.47	6.37	8.79	10.00
COST_SSC_1	Screening/Surveillance Colonoscopy	133,661	49.50%	4.95	1.95	4.40	8.72
COST_IHCL_1	Intracranial Hemorrhage or Cerebral Infarction	126,484	46.84%	6.39	2.92	6.71	9.95
COST_COPDE_1	Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation	117,795	43.62%	7.19	4.11	7.28	10.00
COST_KA_1	Knee Arthroplasty	117,519	43.52%	5.38	2.49	4.89	8.99
COST_FIHR_1	Femoral or Inguinal Hernia Repair	114,933	42.56%	5.95	2.53	6.22	9.05
COST_PHA_1	Elective Primary Hip Arthroplasty	107,251	39.72%	5.56	2.34	5.02	9.20

Measure ID	Measure Name	Number of MIPS Eligible Clinicians Scored on the Measure	Percentage of MIPS Eligible Clinicians Scored on the Measure (Out of All MIPS Eligible Clinicians Scored on Cost)	Mean Measure Score	10 th Percentile Measure Score	50 th Percentile Measure Score (Median)	90 th Percentile Measure Score
COST_FOPCI_1	Elective Outpatient Percutaneous Coronary Intervention (PCI)	105,450	39.05%	5.15	2.23	4.81	8.53
COST_LPMSM_1	Lumpectomy, Partial Mastectomy, Simple Mastectomy	105,399	39.03%	6.21	2.83	6.33	9.14
COST_CCLI_1	Revascularization for Lower Extremity Chronic Critical Limb Ischemia	104,050	38.53%	6.65	3.21	6.90	9.33
COST_RUSST_1	Renal or Ureteral Stone Surgical Treatment	103,134	38.19%	5.88	2.85	6.06	8.75
COST_LGH_1	Lower Gastrointestinal Hemorrhage (groups only)	100,194	37.10%	6.32	2.75	6.57	9.63
COST_MR_1	Melanoma Resection	90,569	33.54%	5.40	2.46	5.44	8.12
COST_NE CABG_1	Non-Emergent Coronary Artery Bypass Graft (CABG)	88,720	32.85%	5.85	1.99	5.63	9.89
COST_HAC_1	Hemodialysis Access Creation	88,591	32.81%	5.55	2.34	5.45	9.12
COST_LSFDD_1	Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels	88,391	32.73%	5.73	2.47	5.77	9.09
COST_CRR_1	Colon and Rectal Resection	84,821	31.41%	6.01	2.29	5.98	9.13
COST_IOL_1	Routine Cataract Removal with Intraocular Lens (IOL) Implantation	81,511	30.19%	5.47	2.80	4.69	10.00
COST_AKID_1	Acute Kidney Injury Requiring New Inpatient Dialysis	64,057	23.72%	5.64	2.30	5.85	9.64

Measure ID	Measure Name	Number of MIPS Eligible Clinicians Scored on the Measure	Percentage of MIPS Eligible Clinicians Scored on the Measure (Out of All MIPS Eligible Clinicians Scored on Cost)	Mean Measure Score	10 th Percentile Measure Score	50 th Percentile Measure Score (Median)	90 th Percentile Measure Score
COST_STEMI_1	ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)	35,684	13.21%	6.3	2.38	6.37	10.00

2.3 Improvement Activities Performance Category

- “Provide 24/7 Access... to Patient’s Medical Record” remains the most reported improvement activity (same as in 2021).
- Three improvement activities that weren’t among the top 10 improvement activities in 2021 are present in the 2022 performance year: **(1)** Use of telehealth services that expand practice access (reported by 48,299 clinicians), **(2)** implementation of medication management practice improvements (reported by 39,236 clinicians), and **(3)** collection and use of patient experience and satisfaction data on access (reported by 37,051 clinicians).

Table 21. 20 Most Frequently Reported Improvement Activities in 2022

Activity ID	Activity Name	Number of Clinicians Who Reported the Activity	Percentage of Clinicians Who Reported the Activity (Out of All MIPS Eligible Clinicians Scored on Improvement Activities)
IA_EPA_1	Provide 24/7 Access to MIPS Eligible Clinicians or Groups Who Have Real-Time Access to Patient’s Medical Record	146,828	25.36%
IA_BE_4	Engagement of patients through implementation of improvements in patient portal	122,244	21.11%
IA_PSPA_16	Use of decision support and standardized treatment protocols	101,660	17.56%
IA_BE_6	Regularly Assess Patient Experience of Care and Follow Up on Findings	93,814	16.20%
IA_CC_13	Practice Improvements for Bilateral Exchange of Patient Information	81,722	14.11%
IA_EPA_2	Use of telehealth services that expand practice access	48,299	8.34%
IA_CC_2	Implementation of improvements that contribute to more timely communication of test results	45,514	7.86%

Activity ID	Activity Name	Number of Clinicians Who Reported the Activity	Percentage of Clinicians Who Reported the Activity (Out of All MIPS Eligible Clinicians Scored on Improvement Activities)
IA_PM_16	Implementation of medication management practice improvements	39,236	6.78%
IA_EPA_3	Collection and use of patient experience and satisfaction data on access	37,051	6.40%
IA_PSPA_20	Leadership engagement in regular guidance and demonstrated commitment for implementing practice improvement changes	36,704	6.34%
IA_BMH_2	Tobacco use	36,153	6.24%
IA_PSPA_6	Consultation of the Prescription Drug Monitoring program	35,914	6.20%
IA_PSPA_1	Participation in an AHRQ-listed patient safety organization.	32,122	5.55%
IA_BMH_4	Depression screening	30,985	5.35%
IA_PSPA_19	Implementation of formal quality improvement methods, practice changes, or other practice improvement processes	30,410	5.25%
IA_PSPA_18	Measurement and improvement at the practice and panel level	29,633	5.12%
IA_PSPA_21	Implementation of fall screening and assessment programs	28,903	4.99%
IA_CC_1	Implementation of Use of Specialist Reports Back to Referring Clinician or Group to Close Referral Loop	26,403	4.56%
IA_BMH_12	Promoting Clinician Well-Being	22,145	3.82%
IA_BE_1	Use of certified EHR to capture patient reported outcomes	21,835	3.77%

2.4 Promoting Interoperability Performance Category

- A sizable percentage of clinicians reported optional/bonus measures:
 - Approximately 82% of clinicians who were scored in this performance category reported the optional Query of the Prescription Drug Monitoring Program (PDMP).
 - More than 30% of clinicians scored in this performance category reported the optional/bonus Syndromic Surveillance Reporting measure.
 - Almost 27% reported the optional/bonus Public Health Registry Reporting measure.
- More than 93% of clinicians who were scored in the Promoting Interoperability performance category reported the e-Prescribing measure; only 1% of clinicians claimed an exclusion for this measure.
- There were 2 options for meeting the Health Information Exchange (HIE) objective requirements:
 - More than 70% of clinicians receiving a score in this performance category reported the HIE Bi-Directional Exchange measure ("option 2") whereas less than 20% reported the Support Electronic Referral Loops by Sending Health Information and the Support Electronic Referral Loops by Receiving and Reconciling Health Information measures ("option 1").

Table 22. Frequency of Promoting Interoperability Measures Reported in 2022

Objective	Measure ID	Measure Name ³³	Measure Type ³⁴	Number of Clinicians Who Reported the Measure	Percentage of Clinicians Who Reported the Measure (Out of All MIPS Eligible Clinicians Scored on Promoting Interoperability)
e-Prescribing	PI_EP_1	e-Prescribing	Required	391,436	93.56%
	PI_LVPP_1	e-Prescribing Exclusion	Exclusion	4,245	1.01%
	PI_EP_2	Query of the Prescription Drug Monitoring Program (PDMP)	Optional/Bonus	343,203	82.03%
Health Information Exchange (HIE)	PI_HIE_1 ³⁵	Support Electronic Referral Loops By Sending Health Information	Required	74,814	17.88%
	PI_LVOTC_1	Support Electronic Referral Loops By Sending Health Information Exclusion	Exclusion	26,403	6.31%

³³ For more information about the 2022 Promoting Interoperability measures and exclusions, review the [2022 MIPS Promoting Interoperability Measure Specifications \(ZIP\)](#).

³⁴ This performance category includes both required and optional/bonus measures; most required measures have one or more exclusions available for clinicians who qualify. For example, there are 3 exclusions available for the Immunization Registry Reporting.

³⁵ There were 2 options for fulfilling the HIE objective requirements in the 2022 performance year: Clinicians could **either** report **(1)** PI_HIE_1 and PI_HIE_4 **or** **(2)** PI_HIE_5.

Objective	Measure ID	Measure Name ³³	Measure Type ³⁴	Number of Clinicians Who Reported the Measure	Percentage of Clinicians Who Reported the Measure (Out of All MIPS Eligible Clinicians Scored on Promoting Interoperability)
	PI_HIE_4 ³⁵	Support Electronic Referral Loops By Receiving and Reconciling Health Information	Required	79,009	18.88%
	PI_LVITC_2	Support Electronic Referral Loops By Receiving and Reconciling Health Information Exclusion	Exclusion	22,215	5.31%
	PI_HIE_5 ³⁵	Health Information Exchange (HIE) Bi-Directional Exchange	Required	295,530	70.63%
Provider to Patient Exchange	PI_PEA_1	Provide Patients Electronic Access to Their Health Information	Required	395,526	94.53%
Public Health and Clinical Data Exchange	PI_PHCDRR_1	Immunization Registry Reporting	Required	347,010	82.94%
	PI_PHCDRR_1_EX_1	Immunization Registry Reporting Exclusion (1)	Exclusion	46,896	11.21%
	PI_PHCDRR_1_EX_2	Immunization Registry Reporting Exclusion (2)	Exclusion	1,399	0.33%
	PI_PHCDRR_1_EX_3	Immunization Registry Reporting Exclusion (3)	Exclusion	1,190	0.28%
	PI_PHCDRR_3	Electronic Case Reporting	Required	286,332	68.44%
	PI_PHCDRR_3_EX_1	Electronic Case Reporting Exclusion (1)	Exclusion	19,536	4.67%
	PI_PHCDRR_3_EX_2	Electronic Case Reporting Exclusion (2)	Exclusion	5,300	1.27%
	PI_PHCDRR_3_EX_3	Electronic Case Reporting Exclusion (3)	Exclusion	23,802	5.69%
	PI_PHCDRR_3_EX_4	Electronic Case Reporting Exclusion (4)	Exclusion	61,665	14.74%

Objective	Measure ID	Measure Name ³³	Measure Type ³⁴	Number of Clinicians Who Reported the Measure	Percentage of Clinicians Who Reported the Measure (Out of All MIPS Eligible Clinicians Scored on Promoting Interoperability)
	PI_PHCDRR_2	Syndromic Surveillance Reporting	Optional/Bonus	127,428	30.46%
	PI_PHCDRR_4	Public Health Registry Reporting	Optional/Bonus	112,851	26.97%
	PI_PHCDRR_5	Clinical Data Registry Reporting	Optional/Bonus	50,228	12.00%

2.5 Unweighted Performance Category Scores³⁶

- The improvement activities performance category had the highest mean and median scores (almost 96%) and contributed to the final score of the most clinicians (almost 93%).
- Only 43% of MIPS eligible clinicians received a cost performance category, which had the lowest mean and median scores of any performance category.
 - Approximately 57% of MIPS eligible clinicians didn't receive a cost performance score because **(1)** they didn't meet the requirements for any cost measure, **(2)** they were approved for reweighting due to extreme and uncontrollable circumstances, **or (3)** they reported through the APM Performance Pathway (cost isn't scored under this MIPS reporting option).

Table 23. Unweighted Performance Category Scores

Performance Category	Overall Unweighted Mean Score ³⁷	Overall Unweighted Median Score	Number of MIPS Eligible Clinicians Who Received a Score for the Performance Category	Percentage of All MIPS Eligible Clinicians
Quality	74.63%	78.40%	542,482	86.91%
Cost	59.70%	59.02%	270,036	43.26%
Improvement Activities	95.96%	100.00%	579,007	92.76%
Promoting Interoperability	94.94%	100.00%	418,398	67.03%

³⁶ The unweighted score (0% – 100%) is generally determined by dividing *the points earned* by *the points available* in a performance category. For example: Earning 20 out of 40 points for the improvement activities would result in an unweighted score of 50%.

³⁷ The unweighted score is the measure of performance before it's multiplied by the category's weight to determine how many points will contribute to the final score. The unweighted score also allows for comparison between clinicians with different performance category weighting. **For example:** An unweighted quality score of 100% contributes 30 points towards the final score when the category is weighted at 30% of the final score; alternately, the same 100% performance contributes 50 points when the category is weighted at 50% of the final score.

3. 2022 MIPS Final Scores and Associated 2024 Payment Adjustments

After MIPS eligible clinicians select and report on measures and activities, they receive a MIPS final score and associated payment adjustment based on their performance.

In the 2022 performance year MIPS eligible clinicians could be evaluated across all 4 MIPS performance categories – quality, cost, improvement activities, and Promoting Interoperability – for the first time since 2019. As a reminder, cost was reweighted to 0% of the final score for all MIPS eligible clinicians in the 2020 and 2021 performance years because of COVID-19's impact on measure performance.

When MIPS eligible clinicians were scored on all 4 performance categories, the categories had the following weights:

- Quality: 30%
- Cost: 30%
- Improvement Activities: 15%
- Promoting Interoperability: 25%

The Medicare Access and CHIP Reauthorization Act (MACRA) requires MIPS to be a budget-neutral program. Generally, this means the projected negative adjustments must be balanced by the projected positive adjustments. When more clinicians receive a negative payment adjustment, clinicians with a positive payment adjustment see a larger payment adjustment amount.

The 2022 performance year is the final year for the exceptional performance adjustment, which will be paid in the 2024 payment year.

For more information about final scores and MIPS payment adjustments, review the additional resources found in the [Appendix](#).

Key Insights

3.1 Final Scores and Payment Adjustments

- MIPS eligible clinicians who engaged³⁸ in the program had a mean final score of 85 points and mean payment adjustment of 2.40%, whereas non-reporting clinicians³⁷ had a mean score of 48 points (well below the 75-point performance threshold) and a mean payment adjustment of -3.41%.

Table 24. 2022 Final Scores and 2024 Payment Adjustments

Status	Final Score				Payment Adjustment			
	Mean	Median	Minimum	Maximum	Mean	Median	Minimum	Maximum
MIPS Eligible Clinicians (All)	82.90	85.29	0.00	100.00	2.06%	0.92%	-9.00%	8.26%
MIPS Eligible Clinicians (Engaged ³⁸)	85.11	86.68	0.00	100.00	2.40%	1.05%	-9.00%	8.26%
MIPS Eligible Clinicians (Non-Reporting ³⁹)	47.85	75.00	0.00	75.00	-3.41%	0.00%	-9.00%	0.00%

3.2 Final Scores and Payment Adjustments by Practice Size, Special Status, and Participation Option

- Clear differences in mean final scores emerge between engaged and non-reporting clinicians, regardless of practice size:
 - The mean final score for engaged clinicians in every practice size was above the 75-point performance threshold (positive payment adjustment), whereas non-reporting clinicians in every practice size had a mean score below the 75-point performance threshold (negative payment adjustment). (Table 25a)
 - While solo practitioners had the lowest mean final score overall (below the 75-point performance threshold), **engaged solo practitioners had a mean final score over 78 points and a median final score over 86 points**. By contrast, non-reporting solo practitioners had a mean final score below 31 points and a median final score just above 18 points. (Table 25a)
- Clinicians participating in MIPS as an APM Entity had the highest mean and median final scores and payment adjustments. (Table 26)

³⁸ **Engaged clinicians** are those who submitted at least one measure, attestation or activity (or had this data submitted on their behalf), or who participated in a MIPS APM and received automatic credit in the improvement activities performance category because of their APM participation. Data could have been submitted at the individual, group, virtual group, or APM Entity level.

³⁹ **Non-reporting clinicians** were individually eligible for MIPS (and therefore required to participate) but **didn't actively submit data**. This includes clinicians who qualified for reweighting in one or more performance categories due to extreme and uncontrollable circumstances, exception applications, special status, or clinician type. These clinicians may still have been scored on administrative claims measures automatically calculated by CMS for the quality and cost performance categories.

Table 25a: 2022 Final Scores and 2024 Payment Adjustments by Practice Size

Practice Size ⁴⁰	Final Score				Payment Adjustment			
	Mean	Median	Minimum	Maximum	Mean	Median	Minimum	Maximum
1 Clinician (Solo Practitioner: All)	54.33	75.00	0.00	100.00	-1.89%	0.00%	-9.00%	8.26%
1 Clinician (Solo Practitioner: Engaged ⁴¹)	78.68	86.37	0.00	100.00	1.89%	1.02%	-9.00%	8.26%
1 Clinician (Solo Practitioner: Non-Reporting ⁴²)	30.81	18.15	0.00	75.00	-5.54%	-9.00%	-9.00%	0.00%
2 – 15 Clinicians (All)	76.59	84.61	0.00	100.00	1.40%	0.86%	-9.00%	8.26%
2 – 15 Clinicians (Engaged)	84.80	89.18	0.00	100.00	2.73%	1.67%	-9.00%	8.26%
2 – 15 Clinicians (Non-Reporting)	43.11	75.00	0.00	75.00	-4.01%	0.00%	-9.00%	0.00%
16 – 99 Clinicians (All)	81.55	83.58	0.00	100.00	1.74%	0.77%	-9.00%	8.26%
16 – 99 Clinicians (Engaged)	83.35	85.19	0.00	100.00	2.04%	0.91%	-9.00%	8.26%
16 – 99 Clinicians (Non-Reporting)	60.03	75.00	0.00	75.00	-1.88%	0.00%	-9.00%	0.00%
100+ Clinicians (All)	85.55	86.50	0.00	100.00	2.43%	1.03%	-9.00%	8.26%
100+ Clinicians (Engaged)	85.78	86.78	7.50	100.00	2.47%	1.05%	-9.00%	8.26%
100+ Clinicians (Non-Reporting)	67.33	75.00	0.00	75.00	-0.97%	0.00%	-9.00%	0.00%

⁴⁰ The practice size is determined by the number of clinicians billing under the practice's TIN in the second 12-month segment of the MIPS determination period (October 1, 2021 – September 30, 2022 for 2022).

⁴¹ **Engaged clinicians** are those who submitted at least one measure, attestation or activity (or had this data submitted on their behalf), or who participated in a MIPS APM and received automatic credit in the improvement activities performance category because of their APM participation. Data could have been submitted at the individual, group, virtual group, or APM Entity level.

⁴² **Non-reporting clinicians** were individually eligible for MIPS (and therefore required to participate) but **didn't actively submit data**. This includes clinicians who qualified for reweighting in one or more performance categories due to extreme and uncontrollable circumstances, exception applications, special status, or clinician type. These clinicians may still have been scored on administrative claims measures automatically calculated by CMS for the quality and cost performance categories.

Table 25b: 2022 Final Scores and 2024 Payment Adjustments by Special Status/Designation

Special Status/ Designation	Final Score				Payment Adjustment			
	Mean	Median	Minimum	Maximum	Mean	Median	Minimum	Maximum
Small Practice ⁴³ (All)	71.52	80.18	0.00	100.00	0.67%	0.46%	-9.00%	8.26%
Small Practice (Engaged ⁴⁴)	83.60	88.07	0.00	100.00	2.59%	1.17%	-9.00%	8.26%
Small Practice (Non-Reporting ⁴⁵)	38.34	25.77	0.00	75.00	-4.60%	-5.91%	-9.00%	0.00%
Rural (All)	81.71	84.10	0.00	100.00	1.72%	0.81%	-9.00%	8.26%
Rural (Engaged)	83.84	85.05	0.00	100.00	2.04%	0.90%	-9.00%	8.26%
Rural (Non-Reporting)	45.05	75.00	0.00	75.00	-3.78%	0.00%	-9.00%	0.00%
Safety Net Provider (All)	86.38	91.57	0.00	100.00	3.33%	3.12%	-9.00%	8.26%
Safety Net Provider (Engaged)	89.51	93.21	0.00	100.00	3.86%	4.12%	-9.00%	8.26%
Safety Net Provider (Non-Reporting)	39.48	27.84	0.00	75.00	-4.50%	-5.66%	-9.00%	0.00%

⁴³ The **small practice special status** identifies clinicians in a practice with 15 or fewer clinicians bill under the practice's TIN in either segment of the MIPS determination period. This means that a practice could have had 16 or more clinicians in 1 segment if there were 15 or fewer in the other segment.

⁴⁴ **Engaged clinicians** are those who submitted at least one measure, attestation or activity (or had this data submitted on their behalf), or who participated in a MIPS APM and received automatic credit in the improvement activities performance category because of their APM participation. Data could have been submitted at the individual, group, virtual group, or APM Entity level.

⁴⁵ **Non-reporting clinicians** were individually eligible for MIPS (and therefore required to participate) but **didn't actively submit data**. This includes clinicians who qualified for reweighting in one or more performance categories due to extreme and uncontrollable circumstances, exception applications, special status, or clinician type. These clinicians may still have been scored on administrative claims measures automatically calculated by CMS for the quality and cost performance categories.

Table 26. 2022 Final Scores and 2024 Payment Adjustments by Participation Option

Participation Option	Final Score				Payment Adjustment			
	Mean	Median	Minimum	Maximum	Mean	Median	Minimum	Maximum
Individual	55.65	75.00	0.00	100.00	-1.73	0.00	-9.00	8.26
Group	82.00	81.41	0.00	100.00	1.57	0.57	-9.00	8.26
Virtual Group	90.20	94.02	67.21	99.17	3.86	4.61	-0.93	7.75
APM Entity	93.81	93.95	46.42	100.00	4.62	4.57	-3.43	8.26

3.3 Mean and Median Final Score Trends

- Although the overall mean and median final scores remained above the performance threshold in 2022, they decreased from 2021.
 - In 2022, the mean and median final scores across all MIPS eligible clinicians were 82.90 and 85.29 points, respectively. (Table 27a)
 - In 2021, the mean and median final scores across all MIPS eligible clinicians were 89.22 and 97.22 points, respectively. (Table 27a)
- There are several program changes in the 2022 performance year that contributed to lower final scores overall:
 - The removal of quality measure bonus points.
 - A change in the complex patient bonus methodology, resulting in fewer clinicians being eligible for this bonus.
 - The calculation of the cost performance category for the first time since the 2019 performance year, along with an expanded number of cost measures that could be attributed to clinicians.
 - Changes to performance category weights.
- Although scores decreased overall in 2022, the data shows an increase in mean and median final scores for subsets of non-reporting clinicians who work in a medium- or large-size practices.
 - This is primarily explained by an increase in the performance threshold from 60 to 75 points; non-reporting clinicians with reweighting in all 4 categories from the automatic extreme and uncontrollable circumstances (EUC) policy or EUC exception application received a final score equal to the performance threshold.
 - Non-reporting solo practitioners had the most observable decrease in scores (Table 27a), which implies that non-reporting solo practitioners were less likely to request reweighting through the EUC exception application than non-reporting clinicians in other practice sizes.

Table 27a. Final Score Trends by Practice Size

	Mean Final Scores			Median Final Scores		
	2019	2021	2022	2019	2021	2022
MIPS Eligible Clinicians (All)	85.65	89.22	82.90	92.32	97.22	85.29
MIPS Eligible Clinicians (Non-Reporting ⁴⁶)	33.55	58.63	47.85	30.00	60.00	75.00
1 Clinician/Solo Practitioner (All)	64.67	71.08	54.33	72.79	60.00	75.00
1 Clinician/Solo Practitioner (Non-Reporting)	30.32	59.99	30.81	30.00	60.00	18.15
2 – 15 Clinicians (All)	78.31	76.10	76.59	90.09	85.54	84.61
2 – 15 Clinicians (Non-Reporting)	31.24	59.91	43.11	30.00	60.00	75.00
16 – 99 Clinicians (All)	84.92	87.47	81.55	92.17	94.43	83.58
16 – 99 Clinicians (Non-Reporting)	37.64	58.70	60.03	30.00	60.00	75.00
100+ Clinicians (All)	89.06	93.27	85.55	92.92	99.14	86.50
100+ Clinicians (Non-Reporting)	54.15	52.33	67.33	30.00	60.00	75.00

⁴⁶ **Non-reporting clinicians** were individually eligible for MIPS (and therefore required to participate) but **didn't actively submit data**. This includes clinicians who qualified for reweighting in one or more performance categories due to extreme and uncontrollable circumstances, exception applications, special status, or clinician type. These clinicians may still have been scored on administrative claims measures automatically calculated by CMS for the quality and cost performance categories.

Table 27b. Final Score Trends by Special Status/Designation

Special Status/Designation	Mean Final Scores			Median Final Scores		
	2019	2021	2022	2019	2021	2022
Small Practice (All)	69.08	73.71	71.52	77.19	66.36	80.18
Small Practice (Non-Reporting ⁴⁷)	30.68	59.90	38.34	30.00	60.00	25.77
Rural Practitioner (All)	85.47	88.44	81.71	92.71	97.18	84.10
Rural Practitioner (Non-Reporting)	33.43	57.32	45.05	30.00	60.00	75.00
Safety Net Provider (All)	83.34	87.20	86.38	91.78	96.23	91.57
Safety Net Provider (Non-Reporting)	30.49	59.26	39.48	30.00	60.00	27.84

3.4 Overall Payment Adjustments

- Approximately 87% of MIPS eligible clinicians either avoided a negative payment adjustment or earned a positive payment adjustment for the 2022 performance year (payment will be adjusted in the 2024 payment year). (Table 28)
- Over 42% of clinicians will receive an exceptional payment adjustment, up to 8.26%, whereas just over 2% of clinicians will receive the maximum negative payment adjustment of -9%. (Table 28)

⁴⁷ **Non-reporting clinicians** were individually eligible for MIPS (and therefore required to participate) but **didn't actively submit data**. This includes clinicians who qualified for reweighting in one or more performance categories due to extreme and uncontrollable circumstances, exception applications, special status, or clinician type. These clinicians may still have been scored on administrative claims measures automatically calculated by CMS for the quality and cost performance categories.

Table 28. 2024 Payment Adjustments Overall

Payment Adjustment Type	Max Negative	Negative	Neutral	Positive Only	Exceptional
Payment Adjustment Range	-9%	-6.75% – 0%	0%	0% – 1.25%	1.55% – 8.26%
					Base adjustment (1.25% – 2.24%) + Exceptional adjustment (0.30% – 6.02%)
Associated Final Score Range	0 – 18.75 points	18.76 – 74.99 points	75 points	75.01 – 88.99 points	89 – 100 points
Percentage of MIPS Eligible Clinicians in Payment Adjustment/Final Score Range (All)	2.09%	11.48%	7.17%	37.04%	42.22%
Percentage of MIPS Eligible Clinicians in Payment Adjustment/Final Score Range (Non-Reporting ⁴⁸)	31.19%	10.03%	58.77%	0.00%	0.00%

3.5 Payment Adjustment by Practice Size, Special Status and Participation Option

- Notably, a greater percentage of clinicians in small practices (2 – 15 clinicians) are receiving an exceptional payment adjustment than clinicians in a medium size practice with 16 – 99 clinicians. (Table 29a)
- Compared to other practice sizes, a higher percentage of solo practitioners will receive the maximum negative payment adjustment of -9%. (Table 29a)
- The percentage of MIPS eligible clinicians in rural practices receiving an exceptional payment adjustment is consistent with MIPS eligible clinicians overall, whereas close to 60% of safety net providers will receive an exceptional adjustment (as compared to 42% of MIPS eligible clinicians overall). (Table 29b)
- Individual participation resulted in the highest percentage of negative payment adjustments; this is the participation option attributed to all non-reporting clinicians. (Table 30)
- Over 93% of clinicians who participated in MIPS through their APM Entity received an exceptional payment adjustment. (Table 30)

⁴⁸ **Non-reporting clinicians** were individually eligible for MIPS (and therefore required to participate) but **didn't actively submit data**. This includes clinicians who qualified for reweighting in one or more performance categories due to extreme and uncontrollable circumstances, exception applications, special status, or clinician type. These clinicians may still have been scored on administrative claims measures automatically calculated by CMS for the quality and cost performance categories.

Table 29a. 2024 Payment Adjustment Types by Practice Size

	Max Negative (-9%)		Negative (-6.75% - 0%)		Neutral (0%)		Positive Only (0% - 1.25%)		Exceptional (1.55%-8.26%)	
	Number AND Percentage		Number AND Percentage		Number AND Percentage		Number AND Percentage		Number AND Percentage	
1 Clinician/Solo Practitioner (All)	4,938	27.53%	3,219	17.95%	4,027	22.45%	1,835	10.23%	3,918	21.84%
1 Clinician/Solo Practitioner (Non-Reporting) ⁴⁹	4,639	50.83%	1,458	15.98%	3,029	33.19%	0	0.00%	0	0.00%
2 – 15 Clinicians (All)	5,617	8.44%	8,525	12.80%	10,314	15.49%	15,099	22.68%	27,029	40.59%
2 – 15 Clinicians (Non-Reporting)	4,910	37.45%	1,397	10.65%	6,805	51.90%	0	0.00%	0	0.00%
16 – 99 Clinicians (All)	1,939	1.55%	20,947	16.73%	14,242	11.38%	43,274	34.57%	44,772	35.77%
16 – 99 Clinicians (Non-Reporting)	1,678	17.34%	525	5.42%	7,475	77.24%	0	0.00%	0	0.00%
100+ Clinicians (All)	552	0.13%	38,973	9.40%	16,183	3.90%	170,996	41.25%	187,810	45.31%
100+ Clinicians (Non-Reporting)	327	6.38%	335	6.54%	4,460	87.08%	0	0.00%	0	0.00%

⁴⁹ **Non-reporting clinicians** were individually eligible for MIPS (and therefore required to participate) but **didn't actively submit data**. This includes clinicians who qualified for reweighting in one or more performance categories due to extreme and uncontrollable circumstances, exception applications, special status, or clinician type. These clinicians may still have been scored on administrative claims measures automatically calculated by CMS for the quality and cost performance categories.

Table 29b. 2024 Payment Adjustment Types by Special Status

	Max Negative (-9%) Number AND Percentage		Negative (-6.75% - 0%) Number AND Percentage		Neutral (0%) Number AND Percentage		Positive Only (0% - 1.25%) Number AND Percentage		Exceptional (1.55%-8.26%) Number AND Percentage	
Small Practice (All)	10,665	12.59%	12,152	14.34%	14,750	17.41%	17,554	20.72%	29,592	34.93%
Small Practice (Non-Reporting ⁵⁰)	9,634	42.63%	2,875	12.72%	10,090	44.65%	0	0.00%	0	0.00%
Rural Practitioner (All)	1,764	2.18%	12,706	15.70%	5,994	7.40%	29,679	36.66%	30,807	38.06%
Rural Practitioner (Non-Reporting)	1,513	34.07%	529	11.91%	2,399	54.02%	0	0.00%	0	0.00%
Safety Net Practitioner (All)	3,383	2.70%	9,251	7.38%	8,290	6.62%	30,908	24.67%	73,441	58.62%
Safety Net Practitioner (Non-Reporting)	3,181	40.55%	1,118	14.25%	3,545	45.19%	0	0.00%	0	0.00%

Table 30. 2024 Payment Adjustment Types by Participation Option

	Max Negative (-9%) Number AND Percentage		Negative (-6.75% - 0%) Number AND Percentage		Neutral (0%) Number AND Percentage		Positive Only (0% - 1.25%) Number AND Percentage		Exceptional (1.55%-8.26%) Number AND Percentage	
Individual	12,273	26.54%	8,401	18.17%	9,647	20.86%	5,784	12.51%	10,137	21.92%
Group	773	0.18%	62,823	14.70%	34,870	8.16%	215,717	50.47%	113,242	26.49%
Virtual Group	0	0.00%	6	6.38%	0	0.00%	29	30.85%	59	62.77%
APM Entity	0	0.00%	434	0.29%	249	0.17%	9,674	6.43%	140,091	93.12%

⁵⁰ **Non-reporting clinicians** were individually eligible for MIPS (and therefore required to participate) but **didn't actively submit data**. This includes clinicians who qualified for reweighting in one or more performance categories due to extreme and uncontrollable circumstances, exception applications, special status, or clinician type. These clinicians may still have been scored on administrative claims measures automatically calculated by CMS for the quality and cost performance categories.

3.6 Payment Adjustments by Clinician Type and Specialty

- Out of all clinician types, Physical Therapists had the highest percentage of clinicians receiving an exceptional payment adjustment (almost 55%) (Table 31).
- Not surprisingly, the payment adjustments for Doctors of Medicine (the most numerous clinician type) were consistent with MIPS eligible clinicians overall (Table 31).
- The specialties with the highest proportion of clinicians receiving negative payment adjustments are Anesthesiology, Orthopedic Surgery, Podiatry and Optometry (Table 32).

Table 31. 2024 Payment Adjustment Types by Clinician Type

Payment Adjustment Type	Max Negative (-9%)		Negative (-6.75% - 0%)		Neutral (0%)		Positive Only (0% - 1.25%)		Exceptional (1.55% - 8.26%)	
	Number AND Percentage		Number AND Percentage		Number AND Percentage		Number AND Percentage		Number AND Percentage	
Anesthesiologist Assistant ⁵¹	-	0.00%	358	20.71%	88	5.09%	659	38.11%	624	36.09%
Certified Nurse-Midwife	2	0.10%	130	6.49%	3	0.15%	975	48.65%	894	44.61%
Certified Registered Nurse Anesthetist	133	0.50%	6,054	22.59%	1,837	6.85%	10,139	37.83%	8,642	32.24%
Clinical Nurse Specialist	7	1.03%	105	15.44%	11	1.62%	286	42.06%	271	39.85%
Clinical Psychologist	84	2.07%	243	5.99%	93	2.29%	1,858	45.83%	1,776	43.81%
Clinical Social Worker	14	0.32%	346	7.98%	34	0.78%	1,598	36.86%	2,343	54.05%
Doctor of Chiropractic (Chiropractor)	62	16.76%	71	19.19%	25	6.76%	130	35.14%	82	22.16%
Doctor of Dental Medicine/Doctor of Dental Surgery (Dentist)	11	2.04%	45	8.35%	7	1.30%	230	42.67%	246	45.64%
Doctor of Medicine ⁵²	10,992	2.72%	43,849	10.86%	35,312	8.74%	149,549	37.02%	164,241	40.66%
Doctor of Optometry	482	6.46%	980	13.14%	403	5.41%	2,642	35.43%	2,949	39.55%

⁵¹ Included in the definition of a Certified Registered Nurse Anesthetist in section 1861(bb)(2) of the Social Security Act.

⁵² Includes Doctors of Podiatric Medicine (podiatrists).

Payment Adjustment Type	Max Negative (-9%) Number AND Percentage		Negative (-6.75% - 0%) Number AND Percentage		Neutral (0%) Number AND Percentage		Positive Only (0% - 1.25%) Number AND Percentage		Exceptional (1.55% - 8.26%) Number AND Percentage	
Doctor of Osteopathy	7	2.62%	27	10.11%	16	5.99%	97	36.33%	120	44.94%
Nurse Practitioner	569	0.65%	10,418	11.86%	3,456	3.94%	32,068	36.52%	41,305	47.04%
Occupational Therapist	36	1.50%	330	13.72%	35	1.46%	994	41.33%	1,010	42.00%
Physical Therapist	380	1.91%	2,088	10.47%	381	1.91%	6,222	31.20%	10,871	54.51%
Physician Assistant	257	0.45%	6,142	10.68%	3,052	5.30%	21,823	37.93%	26,262	45.64%
Qualified Audiologist	10	0.43%	315	13.64%	7	0.30%	973	42.14%	1,004	43.48%
Qualified Speech-Language Pathologist	-	0.00%	52	8.92%	3	0.51%	283	48.54%	245	42.02%
Registered Dietician/Nutrition Professional	-	0.00%	111	7.73%	3	0.21%	678	47.21%	644	44.85%

Table 32. 2024 Payment Adjustment Types by Specialty

Payment Adjustment Type	Max Negative (-9%) Number AND Percentage		Negative (-6.75% - 0%) Number AND Percentage		Neutral (0%) Number AND Percentage		Positive Only (0% - 1.25%) Number AND Percentage		Exceptional (1.55% - 8.26%) Number AND Percentage	
Specialty ⁵³										
Internal Medicine	1,100	2.31%	6,076	12.78%	3,966	8.34%	17,677	37.19%	18,718	39.38%
Family Medicine	605	1.59%	4,035	10.57%	1,946	5.10%	14,067	36.85%	17,516	45.89%
Emergency Medicine	185	0.50%	1,665	4.52%	7,247	19.69%	9,046	24.58%	18,660	50.70%
Diagnostic Radiology	566	1.82%	4,002	12.84%	3,701	11.87%	13,369	42.88%	9,537	30.59%

⁵³ This table is limited to the 20 specialties with the greatest number of MIPS eligible clinicians in the 2022 performance year.

Payment Adjustment Type	Max Negative (-9%)		Negative (-6.75% - 0%)		Neutral (0%)		Positive Only (0% - 1.25%)		Exceptional (1.55%-8.26%)	
	Number AND Percentage		Number AND Percentage		Number AND Percentage		Number AND Percentage		Number AND Percentage	
Anesthesiology	221	1.05%	4,984	23.77%	1,122	5.35%	8,297	39.56%	6,347	30.27%
Orthopedic Surgery	591	3.93%	2,128	14.16%	1,667	11.09%	5,476	36.44%	5,165	34.37%
Cardiology	324	2.22%	1,360	9.31%	915	6.27%	5,372	36.78%	6,633	45.42%
Ophthalmology	603	4.25%	1,398	9.86%	1,713	12.08%	4,597	32.42%	5,868	41.39%
Obstetrics/Gynecology	54	0.39%	1,054	7.67%	87	0.63%	6,353	46.25%	6,187	45.05%
General Surgery	135	1.08%	1,283	10.27%	379	3.03%	4,993	39.95%	5,707	45.67%
Hospitalist	42	0.34%	1,327	10.89%	389	3.19%	4,535	37.23%	5,889	48.34%
Neurology	475	4.48%	826	7.79%	626	5.90%	4,531	42.72%	4,148	39.11%
Gastroenterology	142	1.52%	1,192	12.77%	1,041	11.16%	3,264	34.98%	3,692	39.57%
Dermatology	721	7.82%	569	6.17%	1,656	17.97%	2,627	28.50%	3,643	39.53%
Podiatry	1,877	21.92%	892	10.42%	1,903	22.22%	1,840	21.49%	2,052	23.96%
Psychiatry	328	3.88%	747	8.85%	237	2.81%	3,362	39.82%	3,770	44.65%
Pathology	143	1.72%	770	9.23%	462	5.54%	3,957	47.46%	3,006	36.05%
Optometry	482	6.46%	980	13.14%	403	5.41%	2,642	35.43%	2,949	39.55%
Pulmonary Disease	130	1.84%	799	11.30%	428	6.05%	2,666	37.71%	3,046	43.09%
Urology	210	2.99%	681	9.71%	568	8.09%	2,474	35.26%	3,084	43.95%

3.7 Mean and Median Payment Adjustment Trends

- Overall, the mean payment adjustment increased to 2.06% in 2022 because lower final scores result in a larger magnitude of positive payment adjustments. (Table 33a)
- However, the mean payment adjustment for non-reporting clinicians decreased in 2022. Notably, CMS didn't automatically apply the EUC policy to all MIPS eligible clinicians in 2022 as done in 2019 through 2021 due to COVID-19. Under the automatic EUC policy, non-reporting clinicians receive a neutral payment adjustment. (Table 33a)

Table 33a. Payment Adjustment Trends by Practice Size

	Mean Payment Adjustments			Median Payment Adjustments		
	2019	2021	2022	2019	2021	2022
MIPS Eligible Clinicians (All)	1.06%	1.32%	2.06%	1.27%	1.94%	0.92%
MIPS Eligible Clinicians (Non-Reporting ⁵⁴)	0.02%	-0.23%	-3.41%	0.00%	0.00%	0.00%
1 Clinician/Solo Practitioner (All)	0.64%	0.53%	-1.89%	0.00%	0.00%	0.00%
1 Clinician/Solo Practitioner (Non-Reporting)	0.00%	0.00%	-5.54%	0.00%	0.00%	-9.00%
2 – 15 Clinicians (All)	0.88%	0.34%	1.40%	1.12%	0.26%	0.86%
2 – 15 Clinicians (Non-Reporting)	-0.01%	-0.02%	-4.01%	0.00%	0.00%	0.00%
16 – 99 Clinicians (All)	1.01%	1.18%	1.74%	1.26%	1.54%	0.77%
16 – 99 Clinicians (Non-Reporting ⁵⁵)	0.00%	-0.22%	-1.88%	0.00%	0.00%	0.00%
100+ Clinicians (All)	1.15%	1.59%	2.43%	1.31%	2.22%	1.03%
100+ Clinicians (Non-Reporting)	0.39%	-1.30%	-0.97%	0.00%	0.00%	0.00%

⁵⁴ **Non-reporting MIPS eligible clinicians** who were individually eligible for MIPS (and therefore required to participate) but **didn't actively submit data**. This includes clinicians who qualified for reweighting in one or more performance categories due to extreme and uncontrollable circumstances, exception applications, special status, or clinician type. These clinicians may still have been scored on administrative claims measures automatically calculated by CMS for the quality and cost performance categories.

⁵⁵ **Non-reporting clinicians** were individually eligible for MIPS (and therefore required to participate) but **didn't actively submit data**. This includes clinicians who qualified for reweighting in one or more performance categories due to extreme and uncontrollable circumstances, exception applications, special status, or clinician type. These clinicians may still have been scored on administrative claims measures automatically calculated by CMS for the quality and cost performance categories.

Table 33b. Payment Adjustment Trends by Special Status

	Mean Payment Adjustments			Median Payment Adjustments		
	2019	2021	2022	2019	2021	2022
Small Practice (All)	0.63%	0.26%	0.67%	0.24%	0.02%	0.46%
Small Practice (Non-Reporting ^{1B})	0.00%	-0.02%	-4.60%	0.00%	0.00%	-5.91%
Rural Practitioner (All)	1.07%	1.25%	1.72%	1.29%	1.93%	0.81%
Rural Practitioner (Non-Reporting)	0.02%	-0.46%	-3.78%	0.00%	0.00%	0.00%
Safety Net Provider (All)	1.02%	1.23%	3.33%	1.23%	1.80%	3.12%
Safety Net Provider (Non-Reporting)	-0.04%	-0.13%	-4.50%	0.00%	0.00%	-5.66%

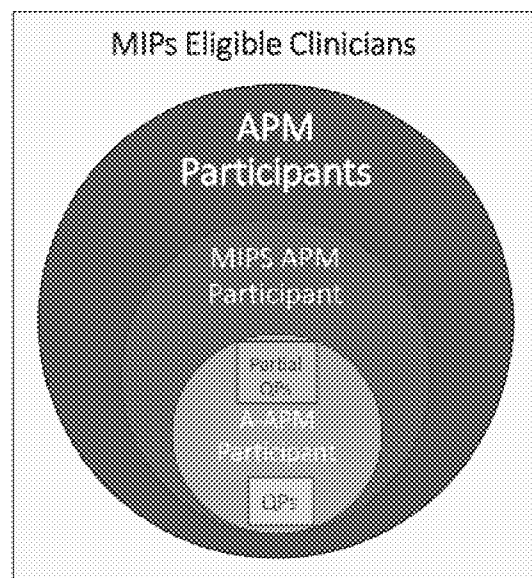
4. Advanced APM Participation

An Alternative Payment Model (APM) is a payment approach that gives added incentive payments to reward health care providers for delivering high-quality and coordinated care. APMs can apply to a specific clinical condition, a care episode, or a population. An Advanced APM is a type of APM that allows participants to seek Qualifying APM Participant (QP) status by achieving threshold levels of payments or patients through their Advanced APM Entity.

Most Advanced APMs are also MIPS APMs.

- QPs receive at least 50% of Medicare Part B payments **or** see at least 35% of Medicare patients through an Advanced APM Entity. They're exempt from MIPS. They aren't eligible to receive a MIPS payment adjustment but will receive a financial incentive for being a QP.
- Partial QPs receive at least 40% of Medicare Part B payments **or** see at least 25% of Medicare patients through an Advanced APM Entity. They can choose whether to participate in MIPS. If they elect to participate, they'll receive a MIPS payment adjustment. Partial QPs aren't eligible for QP incentives.

Clinicians in an Advanced APM who don't achieve QP or Partial QP status based on the thresholds above are evaluated for MIPS eligibility like any other clinician. A clinician can both participate in an Advanced APM and be required to report for MIPS. Refer to the [Appendix](#) for additional resources.



Please note: The designation of the APM does not affect a clinician's eligibility for MIPS. APM participants will still need to participate in MIPS unless they receive QP status or are otherwise exempt.

Table 34: MIPS Eligible Clinicians Who Received a MIPS Final Score and Payment Adjustment from APM Entity Participation

MIPS APM	Number of MIPS Eligible Clinicians	Percentage of MIPS Eligible Clinicians
Medicare Shared Savings Program Accountable Care Organizations	150,266	99.88%
Oncology Care Model	182	0.12%

Table 35: QP Threshold Scores by Advanced APM

Advanced APM	Average Payment Threshold Score	Average Patient Threshold Score
Primary Care First Model	91.64	86.83
Maryland Total Cost of Care Model	74.83	74.00
Vermont ACO Model	73.91	74.50
Medicare Shared Savings Program Accountable Care Organizations	65.53	66.23
Oncology Care Model	63.32	44.81
Direct Contracting Model	62.71	64.98
Kidney Care Choices Model	59.17	37.19
Comprehensive Care for Joint Replacement Payment Model	29.88	16.87
Bundled Payment for Care Improvement Advanced Model	18.44	16.67

Key Insights

- From 2021 to 2022, there was a 26% increase in the percentage of clinicians participating in Advanced APMs. (Table 36)
- From 2021 to 2022, there was a 41% increase in the percentage of clinicians who achieved QP status. (Table 36)
- Almost 21% of clinicians who participated in an Advanced APM without achieving QP status in 2021 achieved QP status in 2022. (Table 37)

Table 36: Qualifying Advanced APM Participant Status

Qualifying APM Participant (QP) Status	Number of Clinicians (Identified by NPI) in 2021	Number of Clinicians (Identified by NPI) in 2022	Number Change from 2021 to 2022	Percentage Change from 2021 to 2022
Advanced APM Participants	333,658	420,591	86,933	26.05%
QP	273,819	386,263	112,444	41.07%
Partial QP	835	370	-465	-55.69%

Table 37. Transition from MIPS Eligible to Qualifying APM Participant

	Number of Clinicians (Identified by NPI, and in an Advanced APM) Not QP in 2021	Number of Clinicians (Identified by NPI) Not QP in 2021 Who Became QP in 2022	Percentage of Clinicians (Identified by NPI) Not QP in 2021 Who Became QP in 2022
All Clinicians	42,782	8,968	20.96%
Small Practice Clinicians	3,554	724	20.37%

Appendix: Additional Resources

Eligibility and Participation Resources

- [How MIPS Eligibility Is Determined \(QPP Website\)](#)
- [2022 MIPS Eligibility and Participation Quick Start Guide \(PDF\)](#)
- [2022 MIPS Eligibility and Participation User Guide \(PDF\)](#)

MIPS Performance Category Resources

Quality

- [2022 Traditional MIPS Quality Requirements \(QPP Website\)](#)
- [2022 Quality Quick Start Guide \(PDF\)](#)
- [2022 Quality User Guide \(PDF\)](#)
- [2022 MIPS Quality Measures](#)

Cost

- [2022 Traditional MIPS Cost Requirements \(QPP Website\)](#)
- [2022 Cost Quick Start Guide \(PDF\)](#)
- [2022 Cost User Guide \(PDF\)](#)
- [2022 MIPS Cost Measures](#)

Improvement Activities

- [2022 Traditional MIPS Improvement Activities Requirements \(QPP Website\)](#)
- [2022 Improvement Activities Quick Start Guide \(PDF\)](#)
- [2022 Improvement Activities User Guide \(PDF\)](#)
- [2022 MIPS Improvement Activities](#)
- [2022 Improvement Activities Inventory](#)

Promoting Interoperability

- [2022 Promoting Interoperability Requirements](#)
- [2022 Promoting Interoperability Quick Start Guide](#)
- [2022 Promoting Interoperability User Guide](#)
- [2022 MIPS Promoting Interoperability Measures](#)
- [2022 Promoting Interoperability Actions to Limit or Restricts Fact Sheet](#)
- [2022 High Priority Practices SAFER Guide Fact Sheet](#)

Final Score and Payment Adjustment Resources

- [2022 Traditional MIPS Scoring Guide \(PDF\)](#)
- **2022 APP Scoring Guide**, available in the [2022 APM Performance Pathway \(APP\) Toolkit \(ZIP\)](#)
- [2024 MIPS Payment Year Payment Adjustment User Guide \(PDF\)](#)

Advanced APM Resources

- [2022 and 2023 Comprehensive List of APMs](#)
- [Learning Resources for QP Status and APM Incentive Payment](#)




Version History

Date	Comment
05/08/2024	Original Posting.

DOCUMENT PRODUCED IN NATIVE FORMAT

IA AHE 8 Attestation Screenshot

Activities		1 Activities Shown
Achieving Health Equity		
Create and Implement an Anti-Racism Plan <p>Activity ID: 1800888000</p> <p>Create and implement an anti-racism plan using the CMS Disparities Impact Statement or other anti-racism planning tools. The plan should include a clinic-wide review of existing tools and policies, such as value statements or clinical practice guidelines, to ensure that they include and are signed with a commitment to anti-racism and an understanding of race as a political and social construct, not a physiological one. The plan should also identify ways in which issues and gaps identified in the review can be addressed and should include target goals and milestones for addressing prioritized issues and gaps. This may also include an assessment and drafting of an organization's plan to prevent and address racism and/or improve language barriers and accessibility to ensure services are accessible and understandable for those seeking care. The MIPS eligible clinician or practice can also consider including in their plan ongoing training on anti-racism and/or other processes to support identifying explicit and implicit biases in patient care and addressing historic health inequities experienced by people of color. More information about elements of the CMS Disparities Impact Statement is detailed in the template and action plan document at https://www.cms.gov/2020-CMS-Agency-Information/0444/Downloads/Disparities-Impact-Statement-508-rev102018.pdf.</p>		Activity Score 20 <input checked="" type="checkbox"/> Completed  Copyright

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